REPORT TO THE TRUST BOARD IN PUBLIC
26 MAY 2022

Title	**Coroner Regulation 28 Report - Prevention of Future Deaths**
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Purpose of the report

- This report provides a summary of the issues identified by the coroner in respect of Mr Jason Lennon (JL) who experienced a cardiac arrest at the Excel Centre after being restrained; Mr Lennon was under the care of Newham's South Crisis Recovery team
- This repot also provides an update on the progress of the actions being taken to address the learning identified and shortcomings in areas of practice
- The Board is asked to consider whether appropriate assurance has been provided

Key issues

On 31 July 2019, Mr Jason Lennon experienced a cardiac arrest at the Excel Centre after being restrained by six security guards. He was under the care of the Newham's South Crisis Recovery Team (CRT) at the time.

The Trust's serious incident (SI) investigation identified several areas of Mr Lennon's care under the CRT that required improvement.

At inquest, the jury concluded that Mr Lennon died from cardiorespiratory arrest in association with restraint and acute psychotic episode. They found that the following circumstances contributed to his death:

- Failures in community mental health care; and
- The extent and manner of restraint (length of time, facing done in prone position) used by security officers at the Excel Centre

HM Coroner subsequently delivered a Regulation 28 Report (the Report) outlining areas of action for the CRT for the purpose of preventing future deaths. They are:

- Expert Psychiatric evidence indicated that Mr Lennon was a suitable candidate for the Care Programme Approach mental health pathway and that the use of this pathway would have reduced the risk of acute deterioration in his Mental State. The CRT failed to appropriately monitor whether Mr Lennon was on a care pathway appropriate to his needs.
- The CRT undertook a flawed review of Mr Lennon's mental state on 29/7/2019 which failed to assess, that Jason was in relapse and a risk of harm to himself and others. Factors which contributed to this failure where:
    a. CRT staff did not effectively review the medical records prior to assessing Jason.
    b. The CRT did not communicate important information between themselves and external stakeholders
    c. The CRT did not document important information arising from the assessment.
- The Trust conducted a Serious Investigation report into the events leading to Mr Lennon's death in November 2019 which made a series of recommendations for action. The action plan was found to be incomplete by 6/2/22 by error attributable to the Trust's Governance team.
- Accepted failings by staff within the CRT fell below standards set by their regulator. There is no evidence before the Court to assess whether ELFT have considered the necessity to make a referral to the regulator.

Actions being taken to address the shortcomings in these areas of practice to improve and ensure safe practice and oversight include: • The CRT is improving systems for medical records review, note taking and communication necessary for undertaking robust risk assessments. • Improved SI systems for documenting and following up actions. • Review of relevant nurse competencies.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☒	Safer, more effective care
Improved staff experience	☒	Clearer expectations and process for staff to follow
Improved value	☐	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	Quality Assurance Committee

Implications

Equality Analysis	There are no identified equality issues.
Risk and Assurance	This report summarised actions taken to respond to risk-related interventions and an assurance of the processes for safe practice and oversight
Service User/Carer/Staff	Delivery of safe reliable care is a priority for the Trust. Service users will benefit high quality response with good risk assessment when they are under the care of the CRT. Greater staff confidence how they respond compassionately will improve their experience of delivering care. Carers will have greater confidence in the safety of their loved ones.
Financial	None.
Quality	The issues highlighted are related to patient safety. Patient safety is the cornerstone of high-quality health care.

Background/Introduction

1.1 On 31 July 2019, Mr Lennon experienced a cardiac arrest at the Excel Centre after being restrained by six security guards. He was under the care of the Newham's South Crisis Recover Team (CRT) at the time.

1.2 The Trust's Serious Incident investigation identified several areas of Mr Lennon's care under the CRT that required improvement.

1.3 At inquest, the jury concluded that Mr Lennon died from cardiorespiratory arrest in association with restraint and acute psychotic episode. They found that the following circumstances contributed to his death:

- Failures in community mental health care; and
- The extent and manner of restraint (length of time, facing done in prone position) used by security officers at the Excel Centre.

1.4 HM Coroner subsequently delivered a Regulation 28 Report (the Report) outlining areas of action for the CRT for the purpose of preventing future deaths. They are:

- Expert Psychiatric evidence indicated that Mr Lennon was a suitable candidate for the Care Programme Approach mental health pathway and that the use of this pathway would have reduced the risk of acute deterioration in his Mental State. The CRT failed to appropriately monitor whether Mr Lennon was on a care pathway appropriate to his needs.
- The CRT undertook a flawed review of Mr Lennon's mental state on 29 July 2019 which failed to assess, that Jason was in relapse and a risk of harm to himself and others.
- Factors which contributed to this failure where:
    - CRT staff did not effectively review the medical records prior to assessing Mr Lennon.
    - The CRT did not communicate important information between themselves and external stakeholders.
    - The CRT did not document important information arising from the assessment.
- The Trust conducted a SI report into the events leading to Mr Lennon's death in November 2019 which made a series of recommendations for action. The action plan was found to be incomplete by 6 February 2022 by error attributable to the Trust's Governance team.
- Accepted failings by staff within the CRT fell below standards set by their regulator. There is no evidence before the Court to assess whether ELFT have considered the necessity to make a referral to the regulator.

2.0 Care Programme Approach

2.1 Despite the opinion of the independent expert it remains the Trust opinion that Mr Lennon did not require to be under the Care Programme Approach.

2.2 NHS England (NHSE) have asked all NHS Mental Health Trusts to move away from the Care Programme Approach (CPA).

2.3 This is outlined in the Community Mental Health Framework for Adults and Older Adults published by NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019 and NHS England's Care Programme Approach Position Statement, 2021.

2.4 The Trust expects this new approach to be fully implemented by March 2024. Albeit, NHSE has not yet published specific details as to what will replace CPA. It is anticipated that this

change will alter the way services are accessed and run on a day-to-day basis including decisions as to appropriate care pathways.

2.5 We are already working at ELFT using DIALOG+ to work with service users to coproduce care plans in the absence of CPA.

2.6 Newham Directorate has received additional recurrent crisis funding (since Mr Lennon's death) for the CRT to ensure that service users continue to receive safe quality care during this transformation and beyond.

2.7 The crisis funding includes two additional support workers to assist with Flexible Assertive Community Treatment (FACT), the CRT's approach to providing "*meaningful intervention-based care for service users"* who are experiencing crisis**.** It operates as another supportive crisis layer for patients under the leadership of the same Consultant Psychiatrist.

2.8 Mr Lennon required a period of more intense mental health intervention than would be available through CPA. FACT (which was only being trialled at the time of his death) would have been more appropriate to his needs.

2.9 The CRT operates FACT by maintaining a list of service users whose urgent needs are difficult to meet with standard CRT care including CPA (service users on CPA are only required to have a monthly review). FACT fills the gap when a service user is in crisis (albeit it does not replace appropriate Home Treatment Team referrals where individuals can be supported at weekends and evenings also). The FACT list is discussed in regular team meetings.

2.10 FACT meetings that take place 3 x each week**.** There is also space in weekly sub- team meetings to discuss any service users that require an even more urgent FACT response.

2.11 Staff are allocated to the service users requiring immediate intervention by matching their skills to needs. These staff work with the service user for the duration of their time under the FACT process along with staff who are a regular part of the service user's care (such as care coordinators) and report back into the meetings on actions.

2.12 The FACT meetings continually monitor the service users progress and agree a risk rating. This is tracked and actions are assigned accordingly. FACT is a dynamic process, and the meetings constantly consider new service users who require FACT input and remove people whose risk rating illustrates a decrease in risk.

2.13 FACT is an important supportive crisis layer that will remain part of the CRT and HTT going forward even as services evolve and move more into primary care. It is a critical safety net that is especially necessary whilst the Trust is moving away from the CPA. Though, it is important to stress that it does not replace CPA.

2.14 The Trust awaits further information from NHSE as to the new structures that will replace CPA.

3.0 Incomplete SI Action Plan

3.1 It is unfortunate that one of the actions on the SI action plan was not completed. The Associate Director of Risk and Governance provided reassurance to the Court via a witness statement that the following actions had taken place to ensure that this does not occur again:

- An Action Plan tracker was introduced in March 2021 onto Datix, our (Incident Management database) which, can be filtered by Action Owner so that Actions outstanding for completion can be readily reviewed and followed up.

- Actions by ‘owner’ are identified at supervision meetings for all SI Reviewers to identify the status of their actions.
- In October 2021, the department introduced a live SI Management Tracker which is used to operationally oversee all aspects of ongoing SIs and SIs listed for Inquest.
- The SI Tracker is updated weekly by the SI Reviewers and status overseen by line managers.
- Both the SI and Action Tracker systems provide granular oversight of what Tasks and Actions are outstanding for completion. This provides line managers with the ability to get accurate position updates on their cases and any associated Actions that are yet to be concluded.
- Whenever a SI Lead Reviewer is leaving the service, their actions are reviewed and completed or handed over to another SI Reviewer for handling - as appropriate. There remains local responsibility for the SI and the oversight of the local Clinical Director and the DMT to complete the action plan.

3.2 Since the inquest, the Trust SI Team has made contact with Flying Angels completing this action.

3.3 The Deputy Borough Director has made further arrangements with Flying Angel’s to conduct a feedback session (by the end of May 2022) to discuss the outcome of the Trust’s SI and the Inquest. Discussion with Flying Angel will also cover how mental health services are structured and the paths for accommodation providers to obtain support for service users who are experiencing deteriorating mental health.

4.0 Concerns regarding practice of registered professionals

4.1 Staff members acknowledged omissions in practice in the care provided to Mr Lennon during the inquest.

4.2 The service leads have started a service wide teaching programme looking at crisis management and escalation. This programme will be implemented across all Community Mental Health Trusts within the Trust.

4.3 The Trust is aware of the issues highlighted at inquest related to specific clinical staff. The practice had not met the Trust threshold for referral of individuals to their professional regulators. The Trust is responding and cooperating with the regulators with information requests. The individuals identified have personal plans to address any issues identified. The NMC have been informed of the actions taken in relation to individuals and are in agreement with this course of action

4.4 In any event a referral has been made by other Interested Persons at inquest. If the outcome shows that the Trust did not interpret the regulator’s threshold correctly it will review its internal processes at that time.

5.0 Action being requested

5.1 The Board is asked to consider whether appropriate assurance has been provided.