the Camphill Village Trust

Communities with adults, some of whom have special needs, caring about the environment, work, economic and social life and further education.

The Kingfisher Offices
9 Saville Street
Malton
North Yorkshire
YO17 7LL
Tel: +44 (0)845 0944638
Fax: +44 (0)1653 228228
trustoffice@cvt.org.uk

The Office of Tom Osborne
Her Majesty's Assistant Coroner for Gloucestershire
Gloucestershire Coroners Court
Corinium Avenue
Barnwood
Gloucester
GL4 3DJ

12 November 2013

Dear Sir

Regulation 28 Report to Prevent Future Deaths

I write in reply to your letter dated 19 September 2013 addressed to [redacted] concerning the Inquest into the death of Daniel Onley.

As requested I provide details of action taken by the Camphill Village Trust (the Trust) to prevent future deaths in response to the matters of concern stated in your letter.

The action the Trust has taken and proposes to take to prevent future deaths.

1 Concern of the Coroner :

That the arrangements in place to support Daniel to take his anti-convulsant medication were insufficient.

Improvements to the safe administration of medicines in Trust services

Audit of existing arrangements

Between 15 May 2013 and 8 July 2013 internal audits were carried out in each of the Trust's nine communities to assess compliance against the requirements of CQC Essential Standards of Quality and Safety Outcome 9 (Management of Medicines).

Where required, managers have acted upon any actions required to improve the safe administration of medicines in their service.

Policy revision

The Trust has completed an extensive review of arrangements concerning the handling of medicines and has implemented a policy focused on the safe administration of medicines in its services. The Trust's Medicines Policy complies with :

- the requirements of the Care Quality Commission regarding the management of medicines, and,
- guidance issued by the Royal Pharmaceutical Society on the safe handling of medicines in social care settings

The key purpose of the policy is to provide managers and staff with a clear framework to ensure best practice when handling medicines and thereby to protect people who use the service from risks associated with the unsafe administration of medicines.

The policy lays out the safe and appropriate arrangements for staff to follow for the obtaining; recording; handling; safe keeping; administering and disposal of medicines.

Future audit of arrangements

Under the direction of the Trust's Operations Director, compliance checks will be carried out periodically (at least once every six months) to assess the quality of service delivery against the requirements of the Trust's Medicines Policy.

2 Concern of the Coroner :

There had been a failure to manage risks associated with Daniel's management of his medication

Improvements to the management of risks associated with the administration of medicines in trust services

The Trust's Medicines Policy lays out the actions managers and staff are required to follow to ensure any risks associated with medicine taken by a person using the service are identified, clearly documented and acted on through :

- **a written risk assessment (A)** to identify any areas of risk the person is exposed to regarding the administration of any medicine they are taking. These risk assessments are required to be routinely reviewed every six months, or sooner if a person's prescription is changed or if any concerns come to light about any aspect of the safe management of medicines. Examples of what could trigger a non-routine re-assessment could include an observed deterioration in a person's health or wellbeing; concern that a

person may not be taking their medicine as prescribed; evidence of lost or otherwise unaccounted for medicines

- **a written mental capacity assessment (B)** to determine the person's ability to safely manage any aspect of handling their medicines. These capacity assessments are required to be reviewed every six months, or sooner if a person's prescription is changed or if any concerns come to light about any aspect of the safe management of medicines, and,

On completion of **(A)** and **(B)**, a written description of the level of assistance a person requires for the safe administration of their medicine is made and entered into the person's care record.

The Trust's Medicines Policy makes it clear to staff that all documentation relating to the administration of a person's medicines must be current, clear, complete and correct.

Regular training on the management of risks has been incorporated into the Trust's staff training plan.

Future audit of arrangements

Under the direction of the Trust's Operations Director, compliance checks will be carried out periodically (at least once every six months) to review the quality of risk assessment documentation, mental capacity assessment documentation and documented support provided to people using the service who take medicine.

3 **Concern of the Coroner** :

The supervision provided to Daniel during the evening of Thursday 21st June 2012 was not sufficient to safeguard Daniel's safety and wellbeing

On 24 September 2013 managers were reminded in writing of the need to ensure that adequate and appropriate supervision commensurate with each person's assessed need is provided at all times in order to ensure the safety and wellbeing of all people using the service.

In the event of any unexpected shortfall in staff numbers or availability, managers are expected to ensure the adequacy and safety of the service through the provision of relief or agency staff.

Specifically, with regard to arrangements in the Grange, i.e. the service where Daniel lived, the posts of General Manager and Care and Support Manager have been established and additional support staff have been appointed with the necessary competencies, knowledge, qualifications, skills and experience to ensure adequacy of staff cover and the safety of the service at all times.

Arrangements to ensure appropriate assistance is available to respond to any untoward or emergency situation occurring between 10.00 pm and 7.00 am is provided in line with assessed need and any clearly documented funding authority expectations.

Future audit of arrangements

The Trust's Operations Director will ensure that the adequacy of service staffing arrangements is reviewed periodically under performance and contract monitoring arrangements.

Other Matters

4 Disciplinary action

Disciplinary action was taken against three individuals regarding their care and support of Daniel.

5 Complaints, Whistle-Blowing, Incident Reporting

The Trust is committed to respond in a timely and effective manner to any concern brought to its attention about its services. Moreover, the Trust will continue to work constructively and positively with partner agencies and regulatory authorities to ensure the safety and wellbeing of people who use its services. This includes continuing to be open and transparent with statutory bodies on known, or suspected, safeguarding concerns.

6 Organisational Learning

The Camphill Village Trust Board of Trustees is committed to ensuring lessons are learned from this tragic incident and supports the Trust's senior managers in taking necessary steps to avoid a similar incident occurring in the future.

The concerns expressed by the Coroner have been shared with operational managers in order to ensure lessons are learned openly and frankly and any required changes to practice are made. For example, as a result of organisational learning, common paperwork has been implemented across the Trust regarding the identification; assessment and management of risks related to handing medicines. The introduction of such a common paperwork and systems of work will greatly assist risk mitigation, improve consistency in operational practice and also provides an essential benchmark for quality auditing purposes.

The Trust also placed this matter before its Safeguarding Board (which is chaired by an independent person) for the Safeguarding Board's analysis and comment in terms of reflective practice and organisational learning.

At its meeting on 5 November 2013 the Safeguarding Board expressed the view that it considers the concerns identified by the Coroner are being addressed and has

asked that regular audits are carried out to ensure continued safe practice and for the findings of these audits to be reported back to the Safeguarding Board.

I trust this letter provides reassurance that the Trust has taken appropriate action to prevent future deaths but please do not hesitate to contact me if further information or clarification is required.

Yours faithfully

Huw John

Chief Executive

The Camphill Village Trust

CC. [redacted]