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Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

19th August 2104

Dear Coroner Hassell,

Re: Mr Ralph Goslin (died 21.01.14)

I write further to your report on the above dated 25th June 2014.

In this report you state that "during the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you." You outlined your concerns in three areas:

- Trust and ward epilepsy management
- Risks associated with bathing
- Trust action in the light of coroner's PFD report

I will address each area individually.

1. Trust and ward epilepsy management

Understanding the holistic care of patients and integrating their psychological and physical care needs, is fundamental to good nursing practice and provision of effective personal care and treatment. It is accepted that insufficient consideration was given to Mr Goslin's physical care needs, in particular educating and supporting Mr Goslin in the implications of living with Epilepsy and the impact this would have on his life.

Specialist training and advice has been commissioned from the National Neurological Commissioning Support Unit, working in conjunction with the National Epilepsy Society to undertake a programme of training across all our inpatient and residential services. This will draw on national best practice and address matters including:

- General epilepsy awareness
- Assessment of risk
- Emergency care and treatment
- Living with epilepsy

The programme will be led by a Specialist Consultant Nurse in Epilepsy and will roll out across the Trust during September and October. 2014. In support of the programme the Trust has taken a range of immediate steps to ensure management of people at risk of epilepsy are effectively managed in the interim. These actions include:

- Issuing of a Trust wide Patient Safety Alert, ensuring all people with epilepsy or at risk of seizures have their care plans immediately reviewed to identify specific risks and ensure action plans are put in place to mitigate these risks (appendix 1).
- Review of all care plans on Montague Ward to ensure these are reviewed on a weekly basis and are reflective of individual need.
- Programmes of audits on Montague Ward to ensure the above arrangements are in place.
- Changes to the staffing arrangements on Montague to increase the leadership capacity in the services.

2. Risks associated with bathing

The Trust has issued a second Patient Safety Alert (appendix 2) ensuring all in-patient services and community houses have protocols in place for the use of bathroom and shower rooms. These protocols ensure:

- Access to communal bathroom and shower rooms are managed
- Levels of supervision for patients are considered
- Patients at risk of seizure have these needs considered.

In addition to the training programme, a well-being resource pack to support people living with epilepsy is being developed. This will be implemented across all in-patient areas and enable staff to engage with patients, families and carer's to raise their awareness and knowledge of the risks people with epilepsy face, and provide practical steps to take on a day to day basis. This will also ensure staff have the particular issues of risks associated with bathing for people with epilepsy in their minds.

Currently the Trust provides services over a number of sites, from a range of different building, of which a small number are purpose built but many have been adapted from a previous use or inherited following organisational change. The Trust has therefore commissioned an independent review of all bathrooms and shower rooms to determine their

suitability for the current patient group and how they meet the needs of patients and disability requirements. This review alongside a review of environmental ligature risks (already completed) will inform decisions about the type of bathroom / shower rooms required for each particular service. This review is due to complete at the end of August 2014. As indicated in court, the Trust has already made the decision to convert communal bathroom/shower rooms in the Huntley Centre at St Pancras Hospital to wet rooms and the programme of work has already commenced. This programme will conclude in September 2014.

3. Trust action in the light of coroner's PFD report

Following the PFD report received on 23rd October 2013 the Trust has initiated a range of actions as indicated in the response of December 18th 2013. These include:

- A programme of works within the acute inpatient service at the Huntley Centre St Pancras Hospital to introduce wet rooms where there were previously bathrooms or shower rooms. These works are due to be completed by September 2014.

- A review of the observation policy, issuing new observation sheets on 19th December 2013, which provide greater detail about patient's location on the ward and a clear rational for enhanced observations, leading to greater interaction with the patient and more frequent reviews.

The Trust also shared with staff the findings of the inquest touching the death of Mr JL. However following the inquest touching the death of Mr RG and the evidence of the Ward Manager on Montague ward that he had not been aware of the inquest findings, the Trust has reviewed the case and how the learning was disseminated.

All ward managers have a professional supervision group with the Deputy Director of Nursing. It was at this meeting that the inquest findings were shared with staff. Unfortunately we now know that the Ward Manager on Montague ward was not able to attend the meeting on that occasion and as a consequence was unaware of the JL inquest findings.

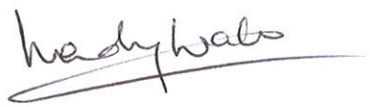
This was a shortfall in our governance arrangements. The process has now been changed so that when recommendations and findings from investigations, complaints or Coroner's PFD are to be shared with a group; they are always followed up with all members of the group after the meeting and communicated in writing.

As with all serious untoward incidents in the Trust, our policy requires an internal investigation. One of the findings from the Internal Investigation, shared prior to the inquest was that the identified ligature risks in the bathroom on Montague Ward were of a level that meant the room should not be used until these issues had been addressed. It was upon this basis that the bathroom was temporarily closed. The timing of the closure was governed by the completion of the internal investigation report and was not done in preparation for the inquest. These ligature risks are programmed to be addressed in September 2014.

I hope that this response addresses the concerns set out in your Prevention of Future Death Report. As acknowledged the Trust services did not identify the enhanced risks associated

with Mr Goslin's epilepsy and bathing and put in place additional observations. This was a shortfall in the care provided to Mr Goslin. I can give assurance that we take the learning from this case and your concerns very seriously. As set out above in our response, the Trust has taken and is taking significant actions to address these concerns and is committed to improve the care and safety of all our service users.

Yours sincerely,



Wendy Wallace
Chief Executive

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