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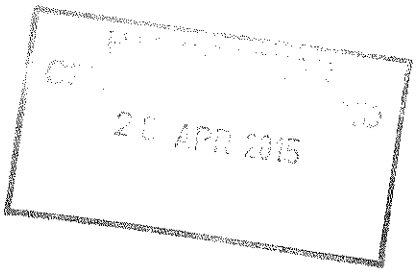

Private and Confidential
Mr Derek Winter LLB
HM Coroner for the City of Sunderland
Civic Centre
Burdon Road
Sunderland
SR2 7DN

Dear Mr Winter

Inquest into the death of Paige Bell – Response to Regulation 28 Report to Prevent Future Deaths

I write in response to your Regulation 28 Report following your investigation into the death of Paige Louise Bell. As you are no doubt aware, the Trust takes all patient deaths very seriously and investigates them very thoroughly to establish if lessons can be learned or services improved. This case was no exception. The Trust carried out a detailed Serious Incident Review and addressed the recommendations which were identified. I understand that you heard detailed evidence about those recommendations and the implementation of them at the inquest. I am informed that [redacted], the group nursing director at the relevant time, provided a statement and addressed these issues in some detail at the inquest. I have asked relevant staff to consider the issues identified again and respond as follows:

Engagement and Observation Policy

While the Trust must and does accept the conclusion of the jury, I believe it is important for me to express concern that our staff present throughout the proceedings were confused by the finding that there were contradictions and ambiguities in the Observation Policy. I am informed that the primary issue of concern at the inquest related to the *choice* made by the relevant clinicians regarding the level of observation (which is of course a complex and challenging clinical issue for patients with Emotionally Unstable Personality Disorder) *rather than the policy* or its implementation.

As set out in the evidence of [redacted] the Trust has already invested a significant amount of time and resource into developing the new Engagement and Observation Policy. This has included consultation amongst internal senior clinical staff, obtaining external expertise from national leading figures, looking carefully at the approach of other Trusts and considering available research into the usefulness of the NICE observation guidelines.

The Trust have carefully considered the changes made to the policy and with expert input have decided to put greater emphasis on clinical assessments and engagement with patients rather than time based observations. It is believed this will reduce risk to patients.

As you heard in some detail in the evidence, the Engagement and Observation Policy clearly sets out the different categories of observation available and gives guidance as to when each of these categories should be considered. Having already invested significant time and both internal and external expertise in the revision of this policy, we do not feel that it is ambiguous. As explained at the inquest, all staff are aware of what each category requires of them. The policy sets out guidance as to when a particular level of observation should be used. However, this is no more than guidance and will need to be considered in conjunction with other factors. Ultimately, observation is a clinical decision and must be specific to the patient and the circumstances. This is particularly important in the context of patients with Emotionally Unstable Personality Disorder as they are always at significant risk. If a risk based observation policy was applied without any flexibility, such patients would always be on "within eyesight" observations and would never leave hospital. That would have significant negative implications for their mental health and ability to integrate into society. The policy therefore takes this into account and acknowledges that if a higher level of observation is going to increase the risk to a patient, other options can be considered.

Record Keeping

In relation to the concerns about space on the new observation record, staff are aware that they can write in the box below if necessary. The RiO number (on our electronic patient record system) is not required on the front sheet, as unlike the continuation sheets, the front sheet has the patient's name and hospital number written on it which will enable the patient to be found on RiO.

With regard to the concerns about the lack of completion of the observation record, staff acknowledged at the inquest that this was not done on this occasion but they were aware that it should have been. Staff are aware that all parts of the document should be completed and this should include a rationale as to why a level of observation is changed. As discussed in [redacted] evidence, the importance of record keeping has been reiterated to staff. Furthermore, [redacted] confirmed that as the revised policy is rolled out across the Trust, staff will receive training on the policy which will include appropriate completion of the new observation record.

In relation to observation records and incident report forms being completed electronically, as [redacted] explained, this is something which the Trust has considered and will continue to do so for observation records. As you will appreciate, introducing such an electronic system is complex. In relation to electronic incident reporting, I can confirm the web based incident reporting project has commenced, with the first site reporting on 1 April 2015, a potential for Hopewood Park to report electronically in June 2015, and the full organisation reporting electronic incidents by October 2015. It is worthy to note that this project has been planned for a number of years, and pre-project planning commenced in July 2014. This project was unrelated to this incident, but the Trust acknowledges the benefits that timely reporting and escalation of incidents brings to improve the quality and safety of care.

In respect to the stated over the presentation of written copies of RiO records, [redacted] explained that this is something which was identified in the Serious Incident Review. He explained that the RiO records are used by staff electronically, and a printed version does not properly reflect how they would be seen or used by staff. In particular the date and time of a meeting or incident is recorded in addition to when the record was made. This allows the entries to be recorded chronologically in relation to the date and time of the meeting or incident. As you heard in evidence, in a very busy and demanding mental health ward

environment staff have to prioritise dealing with patients first and it would be impossible for every decision or action to be recorded immediately. Information can be and is shared in other ways such as through team meetings and handovers. I am informed that staff in this case gave evidence that information was shared and was available to decision makers throughout the relevant timeline. As [redacted] made clear, we acknowledge that entries should be detailed and always made as soon as practically possible and we provide regular staff training to this effect.

I hope that the information provided offers you the assurance that the Trust have invested significant time, effort and resource in investigating the issues you have highlighted with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcomes in the future. Paige Bell's death was a tragedy and we will continue to strive to make improvements wherever possible to minimise the risk of further such tragic incidents.

Yours sincerely

[redacted]

John Lawlor
Chief Executive