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29 March 2016

By email to Leicester.coroner@leicester.gov.uk
Mrs C Mason
Senior Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Mason

Re: David Granville Oswald Hughes

Further to your report dated 09 February 2016, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We carried out a Serious Incident Investigation following Mr Hughes death and reported the actions we have taken as a result of the findings at the inquest. We have also considered the matters of concern that have arisen during the course of the inquest of Mr David Hughes. Leicestershire Partnership NHS Trust takes these matters very seriously and I hope that you and Mr Hughes' family will be satisfied that we have taken the appropriate measures to prevent such an occurrence happening again.

The matters of concern you have raised are as follows:

1. Level 2 observations were not conducted at the prescribed time intervals and periods of up to two hours lapsed between observations that should have been conducted every 15 minutes. When observations were conducted they were not always carried out as per the protocol. Assurances have been given at previous inquests that the performing and recording of these observations would be monitored, audited and staff would be trained regarding the importance of such observations. The same assurances were given at Mr Hughes' inquest. It therefore appears that changes have not been made or if they have they are not working. Alternatively changes may occur in the short-term but they are not being maintained and therefore the monitoring and auditing systems, if implemented, appear not to be working.

Service response

The poor practice demonstrated by staff regarding observations at the time of the incident is unacceptable and is not tolerated. A new version of the Trust's Therapeutic Observation Policy was implemented in 2015 with staff competency based training in the practical application of the policy. The policy is aimed at observing patients in relation to risk of harm, however does include assessment of physical wellbeing. All staff who carry out therapeutic observations are competency checked by a ward nurse or matron before they are allowed to lead on a patient's observations. This is applicable for all ward substantive and bank staff

Further Action

The nursing staff directly involved in this incident were subject to the Trust's Performance and Conduct Policy. As a result, the registered nurse involved has been dismissed and referred to the Nursing and Midwifery Council (NMC). The NMC investigation is still ongoing. The Healthcare Support Worker was also subject to disciplinary procedure and was also dismissed.

All missed observations should be reported through the incident reporting system and are subsequently reviewed by the relevant ward matron. Responsible clinical staff involved in late or missed observations are interviewed and action taken where necessary.

The Therapeutic Observation Policy will be reviewed by 30 April 2016 to consider how the completion of therapeutic observation for physical health concerns should be included or if separate guidance is required.

2. Fluid balance charts were not properly completed. There was no uniformity as to how or when staff would record fluid intake. Some staff would record fluid if they gave Mr Hughes a drink. Some would record if they witnessed Mr Hughes drink it. Therefore, the fluid balance charts were rendered meaningless.

Service Response

The fluid balance chart in use across the Bradgate Unit was devised with the Dietetic service. There is also a Trust Nutrition and Hydration Policy explaining the standard of assessment and monitoring of patients food and fluid intake. However, the use of the fluid chart and the recording on the chart is not consistent by all staff and the service acknowledges the need for urgent improvement in this area.

Further Action

The lead Dietician for Adult Mental Health has been asked to review the fluid chart and its relationship to the Trust Hospital Nutrition and Hydration Policy. It is expected the review of the forms will be completed by the end of April 2016 and implementation will be supported by training to all clinical staff

3. Patient bedrooms are not fitted with a call bell system. The staff rely on patients being able to leave their bedroom and seek help or be able to shout loudly enough to be heard. Clearly, a patient who is so unwell that they can do neither would not be able to alert staff that assistance was required.

Service Response

There are currently 6 rooms identified for patients with physical disabilities in that have call bells in Mental Health Acute Inpatient Services. Traditional call bell systems are not appropriate for Mental Health areas (due to the ligature risks they present), which means the Trust does not have call bells fitted to all Mental Health bedroom areas. However, the service is currently completing a review of appropriate options.

Further Action

The service will conduct an appraisal and feasibility study to facilitate appropriate (individual patient) call-bell facilities by 31 July 2016. The preferred options will be presented to the Service Finance and Performance Committee by September 2016 for investment decision.

During the interim period, increased observations levels will be set for those patients who present as physically unwell. The frequency of these observations will be agreed within the multi-disciplinary team and adjusted as required by clinical assessment. Bradgate Unit patients presenting with physical disabilities or illness will be prioritised admission into our disabled or call-bell equipped bedrooms.

4. The nursing staff who gave evidence were Registered Mental Health Nurses or Health Care Support Workers. The evidence that they gave suggested they may not appreciate the signs and symptoms of a physical problem /illness. One nurse said that he would not. Although it is understood that discussions have taken place regarding the recruitment of 5 Registered General Nurses to supplement the 2 already in post at the Bradgate Unit and address this concern, it is understood that recruitment has not yet occurred and no date for commencement of recruitment could be given.

Service Response

Although mental health nurses do have training in basic physical healthcare the service acknowledges the benefits to patients of integrating additional General Nurses into each ward's multi-disciplinary team and it is the service's commitment to facilitate this.

Further Action

Although the service has had two physical health lead nurses in post since July 2015, the service acknowledges the practical limitations of a limited sized team. The service has agreed to expand our general nurse team at the Bradgate and has consequently completed a cycle of recruitment into new posts. However, there were no applicants and a second cycle has commenced with a closing date in March 2016. It is acknowledged that

nursing recruitment across all specialist areas is difficult at present and if there are no applicants again the service will review this strategy and consider other workforce diversity options.

We hope this reassures you that we have taken appropriate action in response to your findings in respect of individual staff concerned and the systems and processes supporting the Bradgate Unit's physical healthcare services to provide safe and effective care in order to reduce the risk to our future patients.

Yours sincerely,

Dr Peter Miller
Chief Executive