West London Mental Health NHS Trust

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Dear Mr Bedford,

Thank you for your letter, dated 22nd April 2016, concerning the Inquest into Mr Brand's death and the Regulation 28 report relating to the same inquest.

You raised several matters of concern and I have attempted to address these below.

1) *There were periods during the observation of Mr Brand by nursing staff where the hospital observation policy was not followed correctly. In particular, one nurse gave evidence that he saw no movement from Mr Brand after 06.50 hours for some 45-50 minutes. His view of Mr Brand was obscured by poor lighting in the room, scratches to observation window through which he was observing Mr Brand and by the position in which Mr Brand was lying under heavy bedding. He made no effort to ensure that Mr Brand was safe and well, in line with the policy.*

West London Mental Health Trust and Broadmoor Hospital in particular, has undertaken a lot of work over the past three years to improve the quality of supportive observations. Following the death of Mr Brand, a Grade 2 serious incident review was completed and made a number of recommendations. These included a need to remind ward managers of their responsibility to ensure that the fabric of the ward is maintained appropriately, because of the difficulties identified with the observation window and that managers review actions of staff for adherence to the observation policy.

With regards to the fabric of the ward, the hospital introduced a monthly check of the observation windows of all the rooms on each ward. These are on-going. We have documentary records of these checks and also records of when damage has been identified and reported to our Estates and Facilities. These reports are completed by staff on the ward and are reviewed by the ward manager.

There are escalation procedures should Estates and Facilities not respond to the request to rectify any damage.

A number of initiatives have been undertaken focussing on observations. Following the death and the identified problems with observations, our Practice Development Nurse introduced unannounced out of normal business hours audits of observation practice. We have completed eight such audits since August 2013, the last being in April 2016. If we have identified any concerns with practice during the audits, ward managers have been asked to address these issues with the staff concerned.

In September 2014, the hospital introduced a specific module within our mandatory clinical risk training regarding engagement and supportive observations. This course must be undertaken every three years by all clinical staff and currently 92% of staff are compliant with this training.

In 2014, we introduced a Knowledge Skills Assessment (KSA) record on each ward, relating to enhanced engagement and observations. The ward managers and team leaders complete KSA records for all ward staff likely to undertake enhanced engagement and observations in their areas. Staff are expected to read the policy relating to enhanced engagement and observations, to discuss this with the ward manager or team leader and sign to say they have done so and also the ward manager/team leader has to confirm that they are happy for the member of staff to carry out observations. A yearly audit is completed and is next due in June 2016.

We have undertaken workshops with the theme of observations, both locally and nationally and from 2014 to 2016 the hospital was involved in a CQUIN regarding the best practice in managing risk using supportive observations. This was in conjunction with the other two high secure hospitals in England.

2) *When the door to Mr Brand's room was unlocked at 07.15 on 1st July 2015, no attempt was made to check that he was alive and well in breach of the policy at the time. At least a further 10 minutes passed before it was realised that Mr Brand had not moved and checks revealed him to be unresponsive.*

The staff on the ward did not comply with the policy with respect to the conclusion of night time confinement. The nurse in charge was responsible for unlocking Mr Brand's room door at 07.15 and this did not happen. The staff involved have clearly shown candour and remorse for not complying with this policy and have been made fully aware of their responsibilities.

There has been no evidence of this practice being more widespread, but we introduced standard operating procedures for all nurses in charge of wards, which detail, clearly, expectations and responsibilities. One of these is that they will be present when each door is opened following the conclusion of night time confinement and the nurse in charge must see and speak to each patient. A verbal response must be received (or a deliberate conscious movement, such as a hand wave). This is to ensure the patient's presence and check their general wellbeing.

3) *Having found Mr Brand to be unresponsive, nursing staff did not immediately begin CPR. The evidence shows that it was only the 4th member of staff attending Mr Brand who commenced CPR and there was a delay while the first staff on the scene called for more senior assistance.*

Following Mr Brand's death, the basic life support and automated defibrillator training course was redesigned. It now takes place on ward environments where emergencies are recreated to mimic realistic ward situations, enabling staff to better transfer their skills. It incorporates the in-hospital resuscitation procedures designed by the Resuscitation Council (UK), which in turn is accredited by NICE. Each attendee has the opportunity to perform all stages of the sequences of action required to support the collapsed patient. In keeping with the inquest findings (and recommendations of the Resuscitation Council) the requirement for immediate action and subsequent medical and managerial leadership of the resuscitation process is emphasised. Positive feedback has been obtained from course attendees. For staff expected to complete this course, there is currently 87% compliance.

I have enclosed a copy of a report regarding the training

At the Core Skills Conference on November 24 2015, the Trust received special recognition for this course for innovation and quality in training. It further received a certificate for 'Outstanding Achievement in Core Skills Compliance' for statutory and mandatory training of which this course is a component.

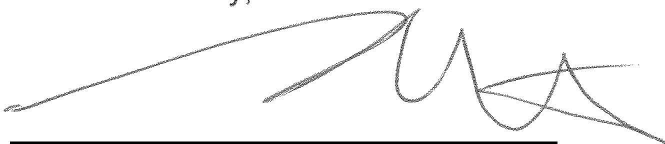
Further action taken by the Trust includes commissioning the Resuscitation Councils Immediate Life Support Courses at Frimley Park Hospital. This is a knowledge and skills based course where medical and nursing staff are taught to recognise and treat the rapidly deteriorating patient. Accordingly the Trusts objective is to act before a cardiorespiratory arrest situation as encountered with Mr Bland.

In May 2015 the Royal College of Physicians published a working party report recommending the implantation of a National Early Warning Score (NEWS). It recommends its use as a surveillance system for all patients in hospitals for tracking their clinical condition, alerting the clinical team to any medical deterioration and triggering a timely clinical response. This is now incorporated into clinical policy at Broadmoor Hospital, the objective of which is again to identify the rapidly deteriorating patient prior to cardiorespiratory arrest.

Finally the hospital is currently undertaking a review of all its emergency admissions to General Hospitals (usually Frimley Park Hospital). Historically the Trust has and continues to undertake reviews of any serious incident. It is expected that by analysing all admissions this will further inform us of the clinical conditions that lead to emergency transfer, areas of good practise and areas of practise where the hospital may need to take action to improve safer decision making.

I hope that the information provided above addresses the concerns raised. If there is any further information you require please do not hesitate to contact me.

Yours sincerely,



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