South London and Maudsley NHS
NHS Foundation Trust

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Ms Henrietta Hill QC
Assistant Coroner
Southwark Coroner's Court
1 Tennis Street,
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Wednesday, July 04, 2018

Dear Ms Henrietta Hill

Re: Prevent future deaths Mr William Dickens

This letter responds to the Prevent Future Deaths report issued to South London and Maudsley NHS Foundation Trust on 8th May 2018 in relation to the death of Mr William Dickens on 10th May 2017 whilst in our care.

In the PFD report you set out five matters of concern that relate to how nurses observed Mr Dickens, how and when the observations were recorded and how effectively observations records are used to maintain the safety of Mr Dickens. You have directed the Trust to take action to eliminate or reduce the risk of death created by the way our nurses carried out and recorded observations for Mr Dickens.

The actions we will take are:

1) The Director of Nursing to use the case as the basis of an internal safety alert 'Blue Light Bulletin' to be sent out to all registered nurses to reinforce the practice standards. ***To be completed by 6/07/18***

2) All Ward Managers to be directed to have a learning conversation with inpatient registered and non-registered nurses about the practice. ***To be completed by 31/07/18***

3) The Therapeutic Engagement and Observation Policy to be reviewed and particular attention to be paid to the clarity of practice standards and the implementation of the policy.

Underway, to be completed by 31/08/18

4) From September 2018 the cohort of newly registered nurses to receive a "Learning the Lessons" presentation, using this case as the basis, of the importance of timely observation and recording in preserving safety and confidence in those we care for. ***Commencing September 2018 and annual thereafter.***

5) From September 2018 the cohorts of nursing in training (year 1-3) to receive a Learning the Lessons presentation, using this case as the basis, of the importance of timely observation and recording in preserving safety and confidence in those we care for. ***Commencing September 2018 and annual thereafter.***

6) Report the PFD and the actions being taken to the Board of Directors as a part of the quarterly public learning lessons report. ***Completed by November 2018***

7) The Director of Nursing as Chair of the E-observation Project Group to develop the timeline for transforming mental health safety and engagement observations into the e-observation framework. ***This is a long term project that is complex to deliver, a time frame is difficult to reliably commit to, the aim will be scoping from January 2019.***

8) The Director of Nursing will commission six monthly snap audits to establish compliance with the standard and take necessary steps to improve compliance. ***Audits commissioned, results to be delivered between August 18 and January 19 and to be considered in the Quality Governance meetings for each Operational Directorate.***

I trust that these actions address the five concerns that are set out in section 5 of the preventing further deaths report. I am happy to answer further questions or provide further information should that be necessary.

Yours sincerely

Beverley Murphy
Director of Nursing