Oxford Health
NHS Foundation Trust

Chief Executive's Office
Trust Headquarters
Warneford Hospital
Warneford Lane
Headington
Oxford
OX3 7JX

Tel: 01865 902769
www.oxfordhealth.nhs.uk

Private & Confidential

Mr C G Butler
HM Senior Coroner for Buckinghamshire
The Coroner's Court
29 Windsor End
Beaconsfield
HP9 2JJ

19 June 2019

Dear Senior Coroner Butler,

Inquest into the death of Emma Butler

Thank you for your letter of 12 April 2019. I write to provide the response on behalf of Oxford Health NHS Foundation Trust. The response follows the order in which you set out your concerns.

I set out your concerns as they appear in your letter.

1. Access to means of self-harm on the ward. Whilst evidence was given as to the difficulty of reducing access to materials of self-harm without restricting fundamentally the rights and activities of patients, it was clear that incidences of self-harm had, on occasions related to the procuring of, concealment of and use of plastic cutlery available to patients on Ruby for self-cutting. The process appears reliant upon voluntary surrender of such items or on their being found rather than on the monitoring of the handing out and proper return of all such items in the context of use at mealtimes. There is a risk of self-harm within the patient cohort on Ruby Ward.

The Trust previously informed you that plastic cutlery is not issued during mealtimes, but there are plastic spoons available at the beverage area on the ward. We acknowledged that plastic spoons do break easily and are capable of being used for self-harm, but explained that patients assessed as being at risk of serious (as opposed to more superficial) self-harm using plastic spoons would either be placed on higher levels of observation, or, potentially, would have their admission reviewed if it was seen to be leading to an increase in self-harm behaviour, or to a change in the patient's usual method of self-harm.

The Trust does not consider that it is practically possible to monitor every plastic spoon on the ward. The Trust is considering if plastic spoons can be replaced by an alternative product that is more resistant to breakage. The Head of Nursing for Buckinghamshire is working with the matrons to identify if there is alternative cutlery available that may be more suitable for this patient group.

2. Access to means of self-harm from outside the ward. The processes for searching and seizing potential self-harm material after return from unescorted leave did not prevent items being brought in from the outside at risk to the particular patient, other patients and staff and the evidence regarding the extent of strip or other searches from staff members was variable. The risk of items being brought onto the ward from outside for use by that patient or others remains where the system for searching and the nature and extent of the search has not prevented the introduction of such items. The understanding of and compliance with specific conditions of leave in the context of searches was unclear.

[redacted] in his evidence used the term "strip search", but what [redacted] intended by the term, i.e. whether he intended to prescribe what a layperson would understand as a "strip search", was not explored in evidence. The use of the term does not reflect the Trust's policy. We agreed that the policy relating to the search of patients and their belongings ought to be updated, and that it ought clearly to set out the hierarchy of searching based on the dynamic assessed risk, as assessed by staff. There is clear instruction available to staff on 'rub down' searching, but no guidance on how to carry out a more extensive search, nor where training could be accessed for the same. It was suggested that a review of the Searching of Patients and their Belongings policy be undertaken. The policy is due before the Trust Quality Committee Clinical Effectiveness Sub-Committee in September 2019. Your concern is being fully explored as part of that review and, if required, revisions to the policy will be implemented.

3. General observations. The process for conducting and recording hourly observations left scope for significant variation on the actual time between and the manner in which such observations of a particular patient were undertaken and recorded. There was an indication that this would be reviewed but the risk remains of an incident of planned or spontaneous self-harm occurring between observations for a patient not on a higher level of observations.

I understand that Counsel for the family made the point during evidence that the way the observations at the time of Emma's death appear to have been completed means a patient could go much longer than an hour without being observed, and you have reiterated this concern.

The concern is fully understood; however, [redacted] confirmed in his oral evidence that, presently, on Ruby ward one member of staff is appointed each hour to check observations, and that this should be done within 10-15 minutes of the hour starting. This avoids the risk of a single patient not being observed hourly at the beginning of each hour.

The 'Safe and Supportive Observations' policy in place stated that:

> *"the minimum requirement for all in-patient clinical areas is that:*
>
> - *At least hourly the allocated nurse should spend time on the ward observing for changes in the mental state or behaviour of all clients and being free to respond to these.*
>
> - *This observation should be recorded on the observation record sheet and any significant interaction recorded in the patient's notes.*
>
> - *It is not acceptable to observe the patient by torchlight through the door in the window of a bedroom."*

The policy is currently undergoing a review. It was last discussed at the Clinical Effectiveness Sub-Committee in April 2019. Your concerns are being considered as part of that review. The revised policy will be presented to the Sub-committee on 18th July 2019 by the Trust's Deputy Director of Nursing for Mental Health.

I can also add that the issue of enhanced observations was the subject of a 2018/19 quality improvement project completed by Oxford Healthcare Improvement (OHI) in partnership with one of our wards, the results of which were reported to our Quality Committee in May 2019. OHI trains and develops staff at the Trust in order to deliver better and safer care through a programme of quality improvement projects, training and research. OHI works with national and international organisations, universities, health and social care providers, commissioners, the academic health science network, patient safety collaborative and industrial partners. The outcome of the project was extremely encouraging and patients and staff have reported very positive outcomes from new approaches to enhanced observations. We will continue to work on this important area to make our observations policy and practices the most effective and safe that they can be.

4. Urgent or emergency access to the ward phone. The concern remains that a patient on unescorted leave outside the Centre who felt they were going to self-harm or who had self-harmed may not get immediate access to support or assistance by calling the specific ward number given to them. Whilst the evidence indicated the balance between positive risk taking, unescorted leave and taking responsibility for decisions and actions, the risk remains that the safety net is not sufficiently robust to ensure that if such a potentially fatal incident occurs, or is likely to occur, a patient can self-alert the ward and expect to receive an immediate response.

I understand that our (then) Ruby ward Modern Matron confirmed in evidence that it is possible that the ward phone number given to patients will go unanswered at times, if a patient on leave (or a relative) attempts to make contact; and that it is right that the focus of ward staff on shift should be towards meeting the needs of patients who are physically present on the ward. Although ward staff have a role in attempting to ensure the safety of

patients who are late returning from leave, those patients who are on leave unescorted are out of the ward *because* an assessment has been made that they have both the capacity and the capability to take responsibility for, and self-manage, their safety while off the ward. It is recognised that for people with EUPD this frequently involves positive risk taking, without which it is likely that they will deteriorate further in hospital.

One action that was discussed was to make it explicit within the leave documentation and welcome pack that when patients are on leave it is possible that the ward phone may not be answered, due to staff attending to the needs of patients on the ward; and to suggest to patients going on leave that if they feel the need to speak to a member of staff, it is suggested that they return to the ward, and speak with their allocated nurse. It should also underline that the ward is not able to provide an immediate response to patients who are on leave and that if patients require an urgent response whilst away from the ward they should contact the emergency services.

The Head of Nursing for Mental Health Services in Buckinghamshire has taken responsibility for the leave documentation and welcome pack to be reviewed. As you will appreciate, any revised documentation would be used across all our wards and it is appropriate that views are taken from colleagues across the Trust. Our aim is to complete the review over the summer.

5. Planning for discharge. The evidence indicated the move towards and importance of shorter periods of admission and planning for discharge into the community. However, the process for keeping all aspects under review and communicating decision-making within the team and with the patient was unclear. The potential lack of certainty and structure into ongoing assessment of risk, leave decisions and monitoring of medication effectiveness is of continuing concern in relation to the management of the risks and behaviour of a patient with personality disorder progressing towards discharge.

The Trust has implemented significant changes since 2017 on Ruby ward in relation to the care of patients with a diagnosis of EUPD. The changes help to provide effective means by which clinical staff can keep under review planning for a patient's discharge into the community, ongoing assessment of risk, leave decisions and monitoring of medication effectiveness. The changes include:

- In line with NICE guidance, the policy is for wards and community teams to work with the patient and their family to try to support the management of crisis in the community. It is recognised that lengthy hospital stays may harm patients with EUPD, and that admissions should be kept short, ideally no more than seven days.

- It is recognised that admission to hospital may contribute to an escalation of risk-behaviours and therefore a deterioration in a patient's presentation. These issues are discussed with patients and their families in weekly ward reviews, where the benefits and risks of continued admission are explored and decisions made with patients.

- We recognise that working with patients who are at chronic high risk is complex and requires clear communication and good team discussion. There is now a regular system of case discussion groups and reflective practice groups, run by psychotherapists from the Complex Needs Service (personality disorder service). This gives the clinical team time to have thorough discussions about complex patients, reducing the chances of boundary shifts and ensuring there is consistency in the way staff work with patients.

- There are MDT handovers every morning.

- There is more access to psychological therapies.

- The ward recognises that the patients on the ward regularly interact with each other, which can often be helpful but sometimes (and in particular with people with an EUPD diagnosis) can increase risk behaviours. This is a factor that the ward considers very carefully when considering a patient for admission and, when necessary, limits the admissions of patients with EUPD.

- We continue to work with the clinical team on the ward to establish other measures we can put in place for monitoring and review of a patient with EUPD if they are admitted to the ward for a longer period of time.

Thank you for bringing your concerns to my attention. I hope that my letter provides you with the assurance that you require.

Yours sincerely

Stuart Bell
Chief Executive