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4 May 2020

Mr D Reid
HM Senior Coroner
Worcestershire Coroner's Court
The Civic Centre
Martin's Way
Stourport-on-Severn
DY13 8UN

Dear Mr Reid

Re: Inquest touching the death of Roy Campbell - Regulation 28 report to prevent future deaths - response

Thank you for your letter dated 9th March 2020, and the enclosed Regulation 28 report. I have read your report with great care and note the concerns that you have raised as a result of the coronial inquiry into the death of Roy Campbell.

In your report, you highlighted the following points of concern and I will respond to each in turn:

1) ***During the inquest, I heard evidence from [redacted], who conducted the trusts own investigation into this incident that, not long after Mr Campbell's death, the trust had introduced a visitor book system for use at the relevant wards at Newtown Hospital. It was originally thought by the trust that this system would be sufficient to prevent patients leaving the ward as Mr Campbell had done. It was not until evidence was given at the first (aborted) inquest into Mr Campbell's death in October 2019, however, that the trust came to the view that this system was inadequate, and further work was done, which came up with a solution involving the use of an electronic system, which will use photographs to identify whether a person wishing to leave the ward, had previously been admitted as a visitor. I am told that, whilst a business case for this proposed new system has been submitted, it is still awaiting approval before it can be implemented.***

2) ***I therefore remain concerned that unless and until such a system has been approved and put in place, there remains a risk of patients absconding from the wards at Newtown Hospital, and if elderly and/or physically compromised, as Mr Campbell was, an increased risk of death in such patients.***

Firstly, I am sorry about the delay in implementing this system. I can confirm that approval for the visitors system has now been granted, and the system has been ordered. The trust has in fact ordered 8 systems to enable installation of this system on all of the wards and rehabilitation units in Worcestershire, under their control. In addition, on 1st April 2020, Mental Health services for Herefordshire were taken over by Worcestershire Health and Care NHS Trust. Therefore, a further 2 systems have been ordered for the wards in Hereford. It is important to the trust, to have a consistent approach across all of our sites, and I would like to assure you that security is always a priority for our patients.

3) ***During the inquest, I also heard evidence that environmental checks, introduced by Athelon Ward to try to identify and remedy any means by which a determined patient could try to leave the secure confines of the ward, were not carried out properly at the time of these events, and are still not enshrined in trust policy, thereby ensuring that staff receive mandatory training on it. I was concerned to be told that only after evidence was heard at this inquest on Monday 2nd March 2020, the current form which was used for checks was revised and staff on both Athelon and Holt ward were instructed to start using it. I was surprised that these revisions were made at such a late stage when the information given in evidence which led to those revisions must have been available to the trust some time ago. I am also informed that it could take a further 2 months for the proper completion of this form to be enshrined in trust policy.***

4) ***I am concerned that unless and until these environmental checks become both the subject of both policy and of mandatory training for all ward staff, there remains a risk that the means by which I vulnerable patient might try to leave the confines of the ward may not be identified in time. If that patient were to be elderly and/or physically compromised as Mr Campbell was, this will lead to an increased risk of death in any such patient.***

The environmental check forms were originally designed by Athelon Ward as a means of, not only identifying modes of exit from the ward, but also other possible environmental risks to patients. They were in use in their original form at the time of Mr Campbell's death, and I am sorry to hear that they were not in fact used correctly at that time.

I am informed by the ward, that during the trusts internal investigation into the incident, it was highlighted that there had been several missed checks on the gate adjoining the ward gardens on the day Mr Campbell absconded from the Athelon ward. I am also told that in evidence in the first (aborted) inquest, it came to light that a member of staff had noticed the gate adjoining the ward gardens to be opened, but had not highlighted this on the form.

I would like to clarify one matter in relation to your concerns around the use of these forms. It is not correct to say that no changes were made to the forms until 2nd March 2020.

Following the evidence in the first inquest in October 2019, the form was amended to ensure that it was simplified and clearer for all staff, and staff were instructed to use this new form from October 2019, and were doing so from then. I do accept that this perhaps could have been done sooner, upon the discovery of the missed checks in the Root Cause Analysis investigation.

In evidence on 2nd March 2020, I understand that a member of staff admitted to pre-signing the environmental check form on the morning of Mr Campbell's absconsion from the ward, rather than at the end of the shift when the checks had actually been completed. This is unacceptable, and the member of staff in question has been spoken to about this by the Ward Manager. It was this additional information, which the trust were not aware of before the evidence was given, which then led to another version of the form being introduced, and the discussion that it should be enshrined into policy.

The form which had been introduced in October 2019 was further amended by the Ward Manager, who was present at Court on Monday 2nd March 2020, and approved by a senior manager within the trust, that same day. By the morning of Tuesday 3rd March 2020, the new amended form had been sent to Athelon Ward, and New Haven ward (a specialist dementia care unit) and staff had been instructed to use the new form with immediate effect.

The new form included a provision for the nurse in charge of each shift, to carry out a check, both at the beginning and at the end of that shift, thus enabling the nurse in charge to ensure that all checks had been done in between their own checks. The nurse in charge is only to sign the form at the end of each shift, after checking that all checks have been completed. This system also ensures that the nurse in charge of both the shift handing over, and the shift receiving, are completing the checks together, which should therefore mean a seamless handover of any issues, should any have arisen.

This form and procedure has now been enshrined into policy, and a copy of the updated policy is enclosed herewith for your consideration. You will note that there are several different environmental checklists in the appendix to the policy. As each ward under the control of the trust has different environmental factors and risks, it is not possible, or safe, to have one single form for all wards. Therefore, as it is now trust policy to use the forms, different forms have been introduced for each ward, which are relevant for the potential risks on that particular ward.

You will note, that the policy also makes it clear that any pre-signing of these forms may result in disciplinary action.

In relation to training, the Trust have very specific general mandatory training which is covered across all services. It would not be appropriate to include the training on the environmental forms as part of the trusts mandatory training. Nor would it be possible to add it to the general list of mandatory training due to the differing nature of the forms.

The use of the environmental checklists will however now be covered in every new member of the ward staff's induction, to ensure that they are properly trained on the form appropriate to the ward where they will be working, and also the policy. All new starters must complete an observations competency form. Training on the new forms and policy will be included here. In addition, the forms are currently the subject of discussion in any existing member of staff's supervision sessions to ensure they are aware of the new amendments to policy and the expectations around the environmental checks themselves, and the use of the forms.

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into the death of Roy Campbell.

Should you require any further updates or clarification in relation to these matters, please do not hesitate to ask.

I confirm that I have not forwarded a copy of this response to any other Interested Person and would therefore be grateful if you could do so as appropriate.

I also confirm that the Trust is content for both the regulation 28 report and the response to be released or published should the Chief Coroner wish.

Yours sincerely

Sarah Dugan
Chief Executive

Encl.