A member of:
Association of UK University Hospitals

NHS
Sussex Partnership
NHS Foundation Trust

Swandean - Trust HQ
Arundel Road
Worthing
West Sussex
BN13 3EP

Tel: [redacted]

Email: [redacted]

Private & Confidential
Her Majesty's Coroners Court
The Senior Coroner, Ms Penelope Schofield
Centenary House
Durrington Lane
Worthing
BN13 2PQ

EMAIL: [redacted]

21st January 2021

Dear Mrs Schofield

Thank you for your letter of 15th December and Regulation 28 and 29 of the Coroner's (Investigations) Regulations 2013 following the inquest of Christopher Patrick Swain which concluded on 12th October 2020.

As you heard during the inquest, there has been considerable reflection and action, within the Trust, following Christopher's tragic death at Langley Green Hospital on 22nd September 2019.

Christopher did not receive the standard of care we expect in the hospital. The clinical team immediately undertook an investigation in to the events leading up to Christopher's death and identified a number of actions and learning that has been shared and cascaded within Langley Green Hospital and across our acute inpatient services. In order to provide you assurance that service improvements have indeed been made Trust-wide, and not just at Langley Green Hospital, my Operational and Service Directors within all inpatient settings have provided me with a full update on the improvements the Trust has made in regards to the issues that you raised. In response to the matters of concern you raise therefore, I shall address each point in turn, adopting your numbering below:

a) *During the evidence there was some confusion amongst staff as to what was required of them when carrying out observations on patients in their rooms. There were different practices adopted by different staff and there appeared to be a custom of not entering a patient's room on the hourly observations so as not to disturb the patients. Sadly because of this practice it was unclear when Christopher had last been seen alive. Whilst the Trust has indicated that all staff have received further training in respect of this I am still not convinced that it is clear as to what is required by staff.*

There has always, within the Trust, been a requirement on all acute inpatient hospital staff, to practice in accordance with the Trust's Therapeutic Engagement and Observation Policy. I was saddened to hear that some of our temporary staff and other Trust staff did not adhere to this Policy during Christopher's admission to Langley Green Hospital. The Policy states 'when a patient appears to be sleeping/ resting, regardless of the time of day staff must continue to monitor their mental and physical health noticing changes in the body position' - importantly it goes on to state 'If a member of staff is not able to observe the patient move or breathe they must ensure the person is conscious which will require entering the bedroom'. In addition to this, the Trust's observation recording sheet as appended to the Policy, states 'If you are unable to observe the patient move or breathe you must ensure that the person is conscious which will require entering the bedroom'. The observation recording sheet used in Christopher's care was however out of date as it was the one from the previous policy (2017 policy) which stated that 'General observations continue at night which will require entering the bedroom to ensure the patient is mentally settled and not experiencing any physical distress or loss of vital signs'. My Clinical and Operational inpatient services Directors inform me that staff, Trust-wide, are aware that a bedroom must be entered where staff cannot ascertain signs of life. This duty is to be conducted in accordance with Code of Practice 8.4 [as included in the Mental Health Act 1983] which states that 'Hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible while maintaining safety' as in psychiatry, there is a requirement to balance the need for promoting sleep/rest and the requirement to make all environments and care the least restrictive whilst ensuring a person's remains safe at all times.

In light of the clinical care review conducted in the wake of Christopher's death, the Trust reconsidered its Therapeutic Engagement and Observation Policy. I and my Clinical, Operational and Service Directors were satisfied that no changes to Policy were required. The issue that arose in Christopher's care was quite clearly, a lack of adherence to Trust Policy by staff. To prevent reoccurrence of non-compliance with Trust Policy within Langley Green Hospital and elsewhere within the Trust, the following actions were taken across all inpatient services:

i. Guidance on observations was refreshed to support staff competency and implementation. All staff now have a pocket guide z card on conducting observations, this can be utilised as an aide memoire and reference guide. The pocket z card describes that 'at least once per shift a member of staff must set aside dedicated time to engage positively and collaboratively with the patient and to assess the current risks and mental state of the individual 'whilst on an acute inpatient ward', to engage therapeutically on each occasion of observation'; As the opportunity for therapeutic engagement depends on the willingness of the individual and their activity at the time, the onus and importance of having a Therapeutic Engagement and Observation Policy in place is that the observations themselves can enable positive therapeutic relationships by establishing good rapport, and being aware of patient's individual needs and changes in presentation;

ii. An easy read poster guide on observations is also now available on all inpatient wards.
iii. Training and competencies on completing observations has been updated. This training is mandatory and must be completed annually and at induction for all agency and bank staff before they are able to commence a shift. There has been evidence submitted of staff completion and ongoing adherence to the requirement for each staff member to complete the induction checklist which includes observations. As of December 2020 there is a 100% compliance for staff who have completed training in Therapeutic Engagement and Observation competency assessments at Langley Green Hospital.
iv. All substantive, bank and Agency staff have access to Carenotes. All observations are now contemporaneously recorded.

b) Following the evidence, the Jury concluded:

(a) that during Christopher's time at Langley Green Hospital no formal review, care plan or adequate risk assessment was carried out in respect of his mental health.

The absence of clinical documentation for Christopher during his admission to Langley Green Hospital was not completed to an expected standard in accordance with Trust Policy. The Trust therefore completed a review of professional conduct of all the staff involved in Christopher's care through HR processes and made referrals to relevant Regulatory bodies. The Langley Green Hospital Leadership team and Trust took immediate action to prevent reoccurrence of any non-compliance with Trust Policy including an immediate review of all care plans, risk assessments and clinical documentation. This has been maintained through audit and competency plans. Feedback was given to the whole team by the Trust Deputy Chief Nurse due to the seriousness and the immediate requirement to reflect and improve. There have, since Christopher's death, been daily risk assessment audit, daily huddles as well as notes audits by Ward Managers with oversight by the senior leadership team. These audits demonstrate as of December 2020 there is 100% adherence to the training in quality record keeping.

(b) that the nursing and clinical records were not kept in accordance with the trust health and record policy.

A new competency framework has been developed and introduced Trust wide to strengthen our systems and processes which reinforces the requirement of stating on the observation chart, the activity of the patient rather than ticking to evidence their presence on the ward. Each member of the Trust inpatient Nursing Team has been required to individually complete the competency check list and such is now integral to the Bank and Agency staff induction checklists - Trust-wide. There is particular focus on this point included in the Eight Steps to Quality and Safety poster now present in the nursing offices across the Trust acute wards. The evidence of all Langley Green Hospital staff completion and ongoing adherence to the requirement for each staff member to complete the induction checklist, which includes observations, has already been submitted to the Court.

Staff were supported with safety days which commenced in December 2019 with specific training on Clinical Risk Assessment which focusses on professional responsibility, accountability, and clinical curiosity.

(c) that there was no recorded evidence that any therapeutic engagement has taken place during the period of Christopher's short stay.

Whilst the Trust have indicated that there has been a review of the professional conduct of all staff involved in this case this does not allay my concerns that these practices are limited to just those staff involved in this case.

The learning and actions taken following the serious incident review into Christopher's death has been shared across the Trust. I accept that there was an absence of documentation on Christopher's care during the period of his admission. It was acknowledged at inquest and during the Serious Incident review that the nurse in charge and allocated nurses did not complete the care plans, risk assessment and Carenotes shift entries to an expected standard, if at all, and that the Nurse did not as appropriate, delegate this to colleagues. I, the Trust, and Langley Green Hospital team were extremely concerned that this was the case, as not having appropriate documentation reduces a teams' ability to communicate risk and give instruction to staff as to the patients expected outcomes. Therefore, a review of all the professional conduct of the staff involved was completed at the time and managed through appropriate internal processes including HR and referrals to relevant Regulatory bodies. From a systems perspective, all Trust inpatient staff have completed competency checks in note writing and ongoing adherence is monitored by Ward Managers who check the content of patient notes weekly in audit form and complete spot checks on a daily basis.

c) Failure to provide staff to accompany a sectioned patient to the emergency department of another Hospital for treatment for a physical condition. Requesting family member to undertake this role puts the patient and/or the family at risk.

The Section 17 MHA 1983 Leave of Absence Policy provides for the Responsible Clinician to grant a detained patient under their care leave of absence from the hospital where they are liable to be detained.

Responsible Clinicians may grant leave for specific occasions or indefinite periods of time. Responsible Clinicians may make leave subject to any conditions which they consider necessary "in the interests of the patient or for the protection of the people" (27.9 MHA Code of Practice 2015)

When completing a section 17 leave form, the Responsible Clinician should include any conditions and support the patient would require during their period of leave. If escorted leave is required the Responsible Clinician must state whose legal custody the patient is to remain in by completing the appropriate tick box and naming the escort if they are not a member of the nursing staff.

In this case, the Responsible Clinician [Dr L] reviewed Christopher prior to his attendance at the general hospital and his section 17 leave was formally prescribed by his doctor. This leave form specified that Christopher was to have a hospital escort to the general hospital and Dr [redacted] noted that the family were accompanying him as he would have familiar faces with him for additional reassurance, in addition to staff. All actions as far as Trust Policy is concerned, were in place when Christopher left Langley Green Hospital to attend the general hospital. However, as noted at the inquest, the issue in this particular case is that Trust Policy for escorted leave was not followed. The family are aware of this and my clinical team have explained this to them in detail. I am assured that the weekly audits being conducted by Ward Managers are ensuring that no patient leaves the Hospital unaccompanied if they are granted section 17 leave for any purpose.

I hope my response herewith provides you with strong assurance of the measures the Trust has taken to ensure its systems are more robust, and that the close monitoring of staff adherence to Trust Policy following Christopher's tragic death, is being checked and evaluated.

Yours sincerely

[redacted]
Chief Executive Officer