East London
NHS Foundation Trust

Trust Headquarters
4th Floor
9 Alie Street
London E1 8DE

25 June 2021

Her Majesty's Acting Senior Coroner Mr Graeme Irvine
Walthamstow Coroner's Court
Queen's Road
Walthamstow
London
E17 8QP

Dear Sir

This is a formal response to your Regulation 28 report dated 30th April 2021 in which you set out your concerns relating to the care Mr Dayal-Singh received from East London NHS Foundation Trust **(the Trust).**

I understand that after hearing evidence from the Trust's Chief Nurse you were assured that the Trust properly investigated the death of Mr Dayal-Singh, identified learning and took appropriate actions. However, several issues arose during the course of your investigation relating to the search, observations and rapid tranquilisation **(RT)** of Mr Dayal-Singh that you would like the Trust to address with the goal of preventing future deaths.

I wish to assure you and the family of Mr Dayal-Singh that the Trust has taken this matter very seriously. Whilst there were already programmes of development work underway to address the shortcomings related to the care Mr Dayal-Singh received; we recognise that this required greater oversight. The Inquest and subsequent report have significantly accelerated this and focussed the Trust on rapid improvement of the areas in question. I explain in detail the steps that we have taken to address your concerns below.

IMMEDIATE ACTION

Due to the seriousness of the concerns outlined in your Regulation 28 report, the content of this report was discussed in person with all of the Borough Lead Nurses and their deputies on 5 May 2021. Further to this, two letters authored by the Chief Nurse and the Directors of Nursing highlighting required actions were sent to the Trust's Borough Lead Nurses and then to all Nursing staff in the Trust's Mental Health Services.

The letter sent to the Borough Lead Nurses via email on 10 May 2021 highlighted the Trust's expectations in relation to patient search, observations, and RT. It emphasised the role of Borough Lead Nurses in monitoring staff training, competencies and keeping records of the

same. It also highlighted immediate changes to the Trust's RT policy. Please find a copy of the letter at **Appendix 1**.

The letter sent out to all Nursing staff via email on 26 May 2021 highlights the same issues focusing on how practice will be monitored by Borough Lead Nurses regularly. Please find a copy of the letter at **Appendix 2**.

I believe these letters relay a clear message to nursing staff about the Trust's expectations in relation to search, observations, and RT. Further, they are preparing staff for the transformational program roll-outs outlined below.

SEARCH

You heard evidence at the inquest that upon admission to Ruby Triage Ward at Newham Mental Health Centre, Mr Dayal-Singh was subject to a property search, yet he retained controlled drugs and a bracelet consisting of a ligature and a blade which had previously been seized by police.

I agree that patient searches must be sufficiently thorough and in-line with Trust Policy to ensure patient and staff safety. Your investigation highlighted that the search of Mr Dayal-Singh was not adequate. It also concerns me that items containing contraband were seized by police and then given back to Mr Dayal-Singh.

Search Policy

In order to address the issue of contraband being handed back to Mr Dayal Singh, the Trust is revising its search policy to explicitly include guidance on:

1) Handover of search information;
2) Reviewing of search information and any relevant documentation; and
3) Disposal/storage of seized items.

The policy is due to be completed on 30 June 2021. It will be disseminated to all staff via the Trust Intranet. A letter to all registered nurses and unregistered staff will follow highlighting the changes.

Search Training Module

To ensure that nursing staff are equipped to carry out robust searches the Trust's Director of Nursing and the Learning and Development Team are creating a 'search' training course. The course will reflect the Trust's updated policy. Completion of the course will be monitored using the Trust's Electronic Staff Record **(ESR)** data base.

The module will be completed on 30th June and Nursing staff will undertake the training every two years. New joiners will receive the training upon induction. The Lead Matron in each directorate will be able to access the ESR training records in real time in order that they are able to monitor compliance easily. This information will be sent to the Directors of Nursing to monitor compliance with training. The resulting compliance percentage will then be forwarded to the Trust Board as part of the Trust's Annual Report for review every August.

Rio Code Changes

Additionally, the Quality and Performance and RiO Teams are developing a code on the Trust's Electronic Medical Records System **(RIO)** which is to be applied every time a search of a patient is undertaken. This will enable Clinical Nurse Manager's, Matron's and Lead Nurses to access up-to-date information about when patient searches are undertaken and allow them to monitor whether such searches are taking place in compliance with the Trust Search Policy. This will be in use by 31 August 2021.

The new training modules and electronic training monitoring platforms (and the interim measure put in place whilst these are set up) will allow senior nursing staff to closely monitor the implementation of the policy changes and encourage broad dissemination of the Search Policy through-out the Trust.

These changes in Search Policy, training, and RiO code changes will be monitored locally through the Directorate Management team. The Borough Director, Clinical Director and Borough Lead Nurse will ensure local actions are undertaken to ensure that the changes are embedded in local services and that these improvement are maintained.

OBSERVATIONS

You heard evidence during your investigation indicating that records of Mr Dayal-Singh's 15 minute intermittent observations were unreliable and falsified. Further, most staff members on Ivory Ward, where Mr Dayal-Singh was detained, had knowledge of this and tolerated it without questioning colleagues.

Observations are a cornerstone of patient safety in Mental Health settings. I wish to assure you that alongside the actions the Trust is taking to address this issue outlined below, it has been escalated and discussed at every level of management throughout the Trust.

Reinforcement the Existing Observation Policy

One of the first steps being taken to address this problem is that all nursing staff (including new staff members and bank staff) working in Trust in-patient services must complete the observations competency checklist that forms part of the Trust's Observation Policy by 30 June 2021. This is irrespective of whether they have completed the checklist in the past**.** Local Ward Matrons managing this process have been identified. They will send the staff records showing completed competency training to the Trust's Learning and Development Team, who will upload the information on each Nurse's ESR. The Matrons will then feed the information about compliance back to the Director of Nursing for senior oversight.

This checklist will be completed annually going forward.

Frequent, local monitoring and reporting of observation practice

Clinical Nurse Managers have already started reviewing nurses' observation practice daily. They are also undertaking weekly night visits on the wards to observe compliance with the observation policy at night - as this has traditionally been overlooked.

These reviews will focus on ensuring there is adequate staffing to deliver prescribed observations and that practice is in keeping with both patients' needs and the Trust's policy. The outcome of the reviews will be discussed weekly with the Ward Matrons.

The Borough Lead Nurses will review the records of this work and feed the information up to the Directors of Nursing. This will provide a clear view to senior management of any issues relating to observation practice within teams so they can directly ensure that any remedial

action can be undertaken immediately. Further, it will allow the Directors of Nursing to identify and manage any broader thematic concerns.

Observations audits

A new system for auditing observations is being implemented. Templates for monitoring auditing observation practice were sent to the Borough Lead Nurses as of 30 May 2021 to be cascaded down to their respective teams. Ward Managers will complete the audits daily and report to Ward Matrons on the numbers of observations being undertaken properly and any patterns of failures or concerns.

A data reporting structure has been developed with the Governance Leads for each directorate so that audit data, review processes, information and learning is reliable, accessible, and transparent. This information is available to the Directorate Management Teams and Directors of Nursing. The Borough Directors, Clinical Directors and Borough Lead Nurses will monitor this within local governance meetings to ensure that locally the observation policy is adhered to and local plans are put in place to ensure it is embedded within local services.

Nurse Observation Training Modules

The Trust's Learning and Development Team in conjunction with the Directors of Nursing are creating an observations module and associated compliance record on the Trust's ESR data base. It is expected that nursing staff will undertake this training annually**.** The Lead Matron in each directorate will be able to access the ESR training records in real time in order that they are able to monitor compliance. This will then be sent to the Directors of Nursing for review and who in turn will forward the resulting compliance numbers to the Trust Board for review. This is scheduled to be in place as of 1 July 2021.

Medical Records Training

Two half day training sessions will be provided to the Borough Lead Nurses on medical record keeping by the Trust's external solicitors within the next 6 months. The training will focus on the legal standard expected for documenting medical practice (especially in relation to observations) and will ensure staff understand when retrospective entries are and are not appropriate and what comprises a misleading record.

The borough Lead Nurses and nominated Matrons will deliver training to staff on induction and at away days that reflects this learning.

E-observations platform

The Trust is developing an e-observation **(e-obs)** recording system to replace the current paper-based system. The intention is that, staff will carry an iPad with direct links to RIO so they can enter patient records in real time. It is expected that this will improve the timeliness and accuracy of observations. A full project plan will be completed by the end of July with anticipated roll out throughout each hospital site from early Autumn 2021.

The Directorate Management Team will maintain local oversight of the implementation of these changes in observations. The Borough Director, The Clinical Director and the Borough lead nurse will ensure there is local monitoring of these changes to ensure that observations are undertaken safely and are of good quality in the local services.

It is my expectation that the increased focus and scrutiny of observation practice and the additional observation training the Trust has developed and is providing alongside

supporting systems will increase good records practice amongst in-patient staff. Further, I anticipate that this work will lead to an environment within the Trust where inappropriate observation practice will be challenged by all staff.

RAPID TRANQUILISATION

You heard evidence at inquest highlighting that Trust staff failed to both follow the Trust's Rapid Tranquilisation (RT) and Monitoring Policy and complete the documentation that is required to ensure patient safety post RT. The jury determined that this failure contributed to Mr Dayal-Singh's death.

I find the evidence that the Trust's policy, processes and procedures were not being followed alarming, especially in light of the jury's conclusion.

Policy Changes

Given the serious implications of the above findings, the Chief Nurse made immediate changes to the substance of the Trust's RT policy. On 10 May 2021(via email), she instructed all Lead Borough Nurses that as of 17 May 2021, RT Monitoring will only be undertaken by Registered Nurses. Further, patients receiving RT medicines will be placed on eyesight observations with a Registered Nurse, only for the first hour, post-administration.

Observations training is a fundamental part of the training and curriculum undertaken by Registered Nurses to receive their diploma. Given this, and their obligations to their professional body to undertake their duties in line with training, I believe that going forward they will be best placed to carry out RT monitoring and reinforce its importance to other staff members.

Additionally, the following areas of the Trust's policy are scheduled to be reviewed by a Subject Matter Expert Group led by Director of Nursing. It will be updated on 19 July 2021 with a specific focus on:

1) Clarifying the definition of RT
2) Describing the parameters of normal physical health limits and highlighting when to refer for medical attention
3) Revising the inappropriate use of word 'ambulatory' with regards to post RT monitoring
4) Mandating the consistent use of paper monitoring charts on all wards/sites (currently staff gather data in different ways and therefore it is not possible to tell if values on RiO are for rapid tranquilisation monitoring or something else).
4) Developing an RT 'Grab Pack' (a succinct checklist and flowchart describing all steps of rapid tranquilisation monitoring) for the wards and incorporated into the Policy as an appendix.

Nurse training

In order to ensure that Nurses are fully aware of both the importance and the content of the Trust's RT policy, processes and procedures the Trust is overhauling its program of training.

Whilst the new training program is in development, as in interim measure, a slide outlining the Trust's policy changes and highlighting the importance of RT monitoring has been included in the existing RT training provided to all Registered Nurses and Nursing Associates. This is delivered annually as part of the Trust's Safe Administration of Medicines Electronic (SAME) training.

The more substantial stand-alone training module in relation to the administration and post-administration monitoring of RT is expected to be completed by 31 August 2021. It will be undertaken alongside the SAME training annually.

By 31 August 2021, the Trust will make an e-learning package on RT available on ESR where its uptake will be monitored in real time by Clinical Nurse Managers and Matrons.

RIO Rapid Tranquilisation Form

Finally, since the e-obs platform outlined above will only be available later this year, as of June 2021 a RIO RT monitoring pack is being used as an interim measure to reinforce the Trust's RT policy.

The pack will be readily available on the Wards and provides standardised guidance as to the process and forms to be filled out before, during and after the RT process. It includes clear directions on how to monitor those who refuse vital signs physical monitoring (assessing level of consciousness and observable early signs of deterioration) and a trigger tool for escalation.

Again, at a local level the Directorate Management Team will ensure these changes relating to monitoring following rapid tranquillization are fully embedded in local services. Through local governance meetings the Borough Director, Clinical Director and Borough Lead Nurse will ensure that monitoring is occurring and that all the changes are in place. This will ensure that observations following rapid tranquilization are carried out safely and are of good quality.

I firmly believe that the changes to the Trust RT policy and the updated training modules will ensure that the events that lead to Mr Singh's death will not reoccur.

Progress Monitoring

The delivery and monitoring of the above improvements is a collective task across disciplines.

Although the onus is largely on the nursing profession; oversight and assurance is monitored jointly through the local operational leadership structures (Borough Directors, Clinical Directors, Borough Lead Nurses) and the corporate and executive leadership of the professions involved (the Directors of Nursing, Chief Pharmacist, Medical Directors, Chief Nursing Officer and Chief Medical Officer).

Daily, weekly and monthly frameworks are now in place to monitor compliance, provide assurance and ensure timescales for implementation are achieved.

I hope this adequately addresses your concerns.

Yours Sincerely

[redacted]
Chief Medical Officer

APPENDIX 1

NHS
East London
NHS Foundation Trust

Trust Headquarters
9 Alie Street
London
E1 8DE

Email: @nhs.net
Website: www.elft.nhs.uk

10th May 2021

SENT VIA EMAIL TO:

Dear

RE: Regulation 28: Report to Prevent Future Deaths

Following a Coroner's inquest in April 2021 into an inpatient death in 2018; the Trust has received a Regulation 28 Report to Prevent Future Deaths; this has also been sent to the Care Quality Commission and Nursing and Midwifery Council.

The main areas of concern highlighted in this death are also of concern in other deaths that have occurred in our inpatient wards. As Lead Nurses, you all have a role to play in ensuring that any resulting actions from this report are carried out and evaluated to a standard that assures us all of the safe clinical practice and oversight.

Over the past eighteen months, we have had several discussions about these themes. The issues identified for action in the report are:

1) Personal searches- It is evident in this case that there was insufficient oversight of how searches had been conducted, when and by whom. This led to the patient retaining dangerous items including drugs and weapons. The death was drug related.
2) Observations- In this case, observations were not undertaken as they should have been and the culture on the ward around observations meant they were a neglected activity and the documentation was falsified. The Coroner found this neglect contributed to the patient's death.
3) Rapid tranquilisation monitoring- This was wholly neglected by the nurses on duty and records falsified. Had monitoring taken place, it is likely that the patients collapse would have been acted upon sooner – with the potential for life saving this implies.

Additionally, although not as part of the PFD, there were concerns about the allocation, delegation and oversight of the shift coordinator role.

Below are actions that you have to lead in your area. As with all systems of training and monitoring, there will be need to change, adapt and improve how they work. However, we need to know how well we are doing now and keep a close eye on this as changes occur:

Point 1. You must have a record of who is trained to search patients. This must be current and the training must form part of induction for staff – in particular key staff such as Band 6 Clinical Practice Leads.

You must have a systematic overview of this documentation and this must be reviewed regularly. This record must be maintained and staff supported to undertake this training. Any equipment related to searching must be maintained/replaced and staff trained in its use.

For Point 2: All staff must be trained in the use of Observations and demonstrate competence in both undertaking and documenting observations. Records of who has been trained and regular monitoring of practice need to be kept by you. Monitoring must take into account practice on night shifts and weekends.

For Point 3: The Chief Nurse has instructed that from 17th May 2021, all Rapid Tranquillisation Monitoring will be undertaken by registered nurses. A further change is that those patients who receive these medications in this manner will be placed on eyesight observations with a Registered Nurse for at least the first hour, post administration.

You need to demonstrate that staff are competent and have sufficient knowledge around the risks associated with rapid tranquillisation; when it is indicated; when and how to monitor and intervene.

All of these issues will require a level of scrutiny that is frequent, credible and robust.

As we progress the improvement work on observations over the coming months, it is anticipated that practice will change. You need to be fully engaged and leading this in your areas. If you require support and help to progress this, then this will be provided.
You are expected to relay and discuss these expectations with your teams – specifically with Matrons and Clinical Nurse Managers – and keep a record of these discussions for later scrutiny.

Finally, we are very aware of just how busy and difficult this last year has been for all and that providing these assurances will be an additional task within the context of the pandemic. Please hold in mind that this is about working to prevent future deaths – as you pay personal attention to this, you will see where the relative issues are that require action or change. We will need to work together to keep focus and ensure that our services are meeting the obligations in relation to this report.

Yours Sincerely,

Chief Nurse Director of Nursing Director of Nursing

APPENDIX 2

NHS
East London
NHS Foundation Trust

Searching, Observation and Physical Health Monitoring Practices

Dear

Information For All Nursing Staff working in Mental Health Settings

A recent Coroner's Inquest into a death on an inpatient ward in ELFT found that poor practice had contributed to the death of the patient.

During the course of the Serious Incident Review and the Inquest, it became clear that certain practices around searching, observation and physical health monitoring fell below acceptable standards.

In light of this, the Coroner has issued a report to the Trust, Care Quality Commission and the Nursing and Midwifery Council instructing that we act to prevent any future deaths by addressing the shortcomings in these practices and assuring the Coroner that any actions are credible and reliable.

There are key requirements for all nursing staff.

1) Patient Searches

Unregistered and Registered Nursing Staff – must be formally trained and deemed competent to search patients and their belongings, know when and how this is permitted and what documentation is required. You must also be able be able to provide evidence of training.

2) Observations

Unregistered and Registered Nursing Staff – must be trained and deemed competent to undertake observations of patients. Documentation of observations must be accurate and contemporaneous. All staff must know the clinical indications for undertaking observations with patients and this activity must be manageable within the staffing resource available.

3) Post Rapid Tranquillisation Patient Monitoring

Registered Nurses – must be trained and deemed competent to undertake RT monitoring. As of the 17th May 2021 only Registered Nurses can undertake RT

monitoring and this monitoring must be within eyesight for at least the first hour post administration. Note – the form of observation described is specifically for RT monitoring purposes and is not the same as Enhanced Observations as per the Observation Policy.

Practice in all of these areas will be monitored very closely. Getting this right is a key priority.

Each clinical area has a Matron who is responsible for each of these activities. The Lead Nurses will work closely with each team to ensure that you are trained and are confident in these clinical and security activities.

Please talk with them for advice and support.

If you are concerned about practices in your area and do not feel you can discuss this with your managers then our Freedom to Speak Up (FTSU) Guardian, can assist.

They can be contacted via the FTSU confidential inbox of [redacted]

Your feedback is enormously important – please let us know your thoughts and opinions on this.

Kind regards,

Chief Nurse

Director of Nursing
(London Mental Health)

Director of Nursing
(Bedfordshire and Luton Mental Health)