Camden and Islington NHS
NHS Foundation Trust

REGULATION 28: PREVENTION OF FUTURE DEATHS REPORT - ABDULLAHI SHARIF ABOKAR

RESPONSE TO THE CORONER, 31 JANUARY 2014

Camden and Islington NHS
NHS Foundation Trust

Response to Regulation 28: Prevention of Future Deaths report

Abdullahi Sharif ABOKAR (died 21.06.12)

Camden & Islington NHS Foundation Trust's ("the Trust") response to the Prevention of Future Death report for Mr Abokar is set out below.

The ward where the death took place, Coral ward, has been the subject of further clinical and quality scrutiny since the inquest. The matron at Highgate Mental Health Centre has raised further concerns about leadership and quality of practice on Coral Ward. As a consequence of the Prevention of Future Deaths report and our subsequent enquiries, we have adopted a "Rapid Improvement Plan" for Coral ward. The Rapid Improvement Plan process is used within the Trust when we are concerned that the quality and/or safety of a particular service is inconsistent with our standards. The Rapid Improvement Plan process establishes a governance process, resources and a timetable to improve the service. The oversight group, Chaired by our Chief Operating Officer has been formed to rigorously monitor the progress against the rapid improvement plan. The response below summarises relevant elements of the plan which will enable us to address the Regulation 28 report's concerns:

Coroner's Concern	Detail	Action
1. Asking the suicide question	Several members of staff looking after him did not ask Mr Abokar if he had thoughts of taking his life. Some, including his ward manager, gave evidence that they thought that asking the question might give a patient the idea of taking his life, though evidence was given by the assistant director of nursing that this thinking is not accordance with training or	The Trust has implemented the following plan to ensure patient safety through staff having competence and confidence in the assessment of suicidal risk in patients. The Trust expects all its clinical staff to regularly ask every patient about suicide, in terms of thoughts or plans and this issue is explored in clinical supervision and through regular monitoring of clinical standards. a) An intensive programme of work commenced on Coral ward on 13th January 2014, called the Rapid Improvement Plan. This

	accepted practice. One mental health nurse said that, although he would ask the suicide question of a patient who appeared isolated or in low mood, he could not ever remember asking that question, despite his work on a secure mental health ward.	contains the following elements: i) A new 'turnaround' nurse manager in place to lead the team. ii) All staff will be assessed against a schedule of core clinical competencies, developed by the deputy director of nursing. Staff demonstrating additional support or training needs will receive these with immediate effect. iii) From 27th January 2014 Coral ward will have the benefit of 2 days per week of Practice Development Nurse time. Practice Development Nurses will account to a new Nurse Manager who is leading Coral ward's turn around work. Practice Development Nurses are tasked with improving the quality of care delivered by clinical staff through: • Enhancing their knowledge and skills. • A focus on improving staff's ability to communicate, perform mental state examinations, write care plans, provide appropriate information to patients and to improve the overall quality of their interactions with patients. • All clinical staff are required to undertake basic (Level 1) training in safeguarding. Further training at Level 2 will be provided to all Coral Ward staff by the Trust Safeguarding lead in February 2014. The aim of this is to enhance the knowledge of skills of this staff group in particular in protecting their patients from potential and actual risk from others. b) Investigation of the ward manager under the Trust disciplinary policy.

		c) Monitoring of the capability of two members of staff to provide appropriate patient care specifically around risk assessment and management due to evidence presented by them in the Coroner's court, and through subsequent assessment of their skills by the matron of the Highgate Mental Health Centre. d) The Trust will commission Acute In-patient Suicide Prevention training from Kings College, London by March 2014 for all inpatient services. e) Led by the Director of Nursing, the Trust is revising its strategy for Risk Management. This will be completed by March 2014 and will outline expectations of staff competency, content of risk assessments and care planning, content of interactions between staff and patients and the ways in which these will be monitored to maintain consistent standards of all staff. f) All staff in our psychiatric intensive care unit, acute inpatient wards, crisis houses and community crisis teams will receive further training in use of a risk assessment and management system from 28th January 2014. This training will be completed 30th April 2014.
2. Resuscitation	The psychiatry doctor who attended the resuscitation in progress (approximately seven minutes after Mr Abokar was discovered), found an ambubag mask on Mr Abokar's face, but no ambubag connected and no person holding the mask. The nurse who had been in charge of Mr Abokar's airway said that she had been giving	a) A revised Trust Resuscitation Policy was approved by the Trust's Quality Committee in November 2013, containing changes in line with national guidance and also directly related to learning from this inquest's findings. b) The Director of Nursing has overall responsibility for policy development, implementation and ensuring CPR standards are

	him mouth to mouth resuscitation, though no other witness in the room saw this. No explanation was provided as to why she would have given mouth to mouth rather than use the ambubag present (even if the ambubag was not connected to a flow of oxygen).	upheld, as resuscitation lead for the Trust. c) Training in 'in-hospital life support' has always been a mandatory requirement for ward staff. This will continue under the revised policy in line with national requirements. d) Due to the infrequent occurrences of CPR within mental health hospital settings, our inpatient units will now perform simulation exercises every 6 months to ensure staff get practice in performing CPR. The matron from each unit has responsibility for organising these, under the guidance of the Deputy Director of Nursing. The first such exercises will take place in April 2014.The exercises will be monitored through our committee structure. e) Management of the resuscitation scene will no longer be with the attending doctor, but with the most senior nurse on duty at the time. This will be the duty nurse or site matron who will have responsibility for coordinating staff actions, and handing over information to attending paramedics. Until the paramedic lead accepts responsibility, the duty nurse or site matron will maintain the lead for managing the resuscitation. f) Training in use of oxygen will now be provided by an independent company contracted to provide this for the Trust. This is a specialist Health and Safety firm. The Trust will ensure that live oxygen cylinders are provided for each training session for this purpose, which will enable staff undergoing training to familiarise themselves fully with the cylinder and how it functions, including the sound it makes when activated. The Deputy Director of Nursing has responsibility for organising this. The Trust will also recommend to the National Resuscitation Council that this should be a component of in-hospital Life support training, as it is not currently stipulated as

		such in their 2013 guidance. g) The nurse identified as responsible for maintaining the airway during this inquest is being managed under the Trust's capability policy.