Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Mr A. Walker,
Senior Coroner,
North London Coroners Court,
29, Wood Street,
Barnet,
EN5 4BE

[redacted]
Executive Director of Nursing, Quality and Governance
Barnet, Enfield and Haringey Mental Health Trust
Trust Headquarters
B2, St. Ann's Hospital
St Ann's Road
London N15 3TH

Tel: 020 8702 3032
Email: [redacted]

4th April 2014

Dear Mr Walker,

Re: Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulation 28 and 29 of the Coroners (Investigations) Regulations 2013 – Mr A. Cowan (Deceased)

I write on behalf of Barnet, Enfield and Haringey Mental Health Trust, as Executive Director of Nursing, Quality and Governance, in response to your Regulation 28 report, following the inquest which concluded on 28th January 2014 touching the death of Mr Adrian Anthony Cowan. At the time of his death Mr Cowan was a detained inpatient within the North London Forensic Service, Barnet, Enfield and Haringey Mental Health Trust.

I would like to assure you that your concerns have been taken seriously by our Trust, and we have taken immediate action to address the matters of concern.

For completeness I would like to address the concerns as they are set out in your correspondence:

1. **That the Trust policy dealing with the staff response did not include a clear set of guidance to those staff members responding to Mr Cowan's collapse nor did the policy include the need, as part of the emergency response, to request the duty doctor to attend.**

I would like to assure you that we have taken immediate action to review the Trust's resuscitation policy, which at the time of Mr Cowan's Death was up to date and was not due to be reviewed until 2015.

The update to the policy will incorporate additional action to be taken in the future in response to the "deteriorating patient", and we will update and expand the "NEWS" Score, which is a nationally recognised tool for assessing patients whose physical health may be deteriorating. The revised policy will make clear the need to contact the duty doctor in the event of a medical emergency.

I would like to clarify that the Trust's resuscitation policy in place at the time of Mr Cowan's death did list the actions to be taken to determine whether a patient was breathing or not, and explained what action was to be taken in such events. We have now displayed a step by step guide within all ward areas within the Forensic Service, and we will be introducing this in all our other inpatient areas. I would further wish to reassure you that the training provided to frontline staff will reiterate the changes in our policy once it has been ratified which I anticipate will have been completed by 30th April 2014.

2. **Some of the nursing staff were not able, when responding to Mr Cowan being found collapsed, act in a calm, coordinated manner and were not able to apply the training they had received in basic life support.**

We recognise that during clinical emergencies some staffs ability to recall procedures and act in a calm manner may be affected, particularly when such practice is not exercised regularly.

I can confirm that within the Forensic Service, all staff have attended the Basic Life Support Training (with the exception of recently appointed staff who have been scheduled to attend future training sessions). All Registered Nurses are expected to undergo Intermediate Life Support Training. There are robust Trust structures in place to monitor attendance at such training and systems to address any areas of variation in compliance across our services.

In order to improve the confidence and competence of staff's application of resuscitation techniques, regular assessments and practical sessions have been implemented using a lifelike manikin, designed to offer a highly realistic platform for the teaching of resuscitation. This approach is being revised and will in future be run regularly across all wards within the Forensic Service and the Trust. I have asked our Resuscitation Officer to conduct unannounced resuscitation scenarios across the Forensic wards so that we may further strengthen staffs ability to respond in an emergency situation.

In addition, the Forensic service has in place regular support structures in the form of support groups to support those staff who may lack confidence, or require guidance on any clinical issue that they may feel unsure of, or lack confidence in.

I would wish to assure you that following all Serious Incidents within the Trust we endeavour to ensure that systems and procedures, as well as individual clinicians' competencies are reviewed to evaluate whether changes are required to reduce the likelihood of similar future events.

I confirm that we have as detailed above taken clear action to address the matters of concern raised by you and I can assure you that we will continue to actively audit resuscitation practices within the North London Forensic Service. If you require any further or additional information for clarification, please feel free to contact me directly.

Yours sincerely,

[redacted]
Executive Director of Nursing, Quality and Governance
CC: [redacted], Clinical Director, North London Forensic Service
CC: [redacted], Lead/Claims Lead
CC: [redacted], Medical Director
CC: [redacted], Resuscitation Officer