PRIORY
GROUP OF COMPANIES

Private and confidential

Dr Sean Cummings
Assistant Coroner
25 Bagleys Lane
Fulham
SW6 2QA

Wednesday 30 April 2014

Dear Dr Cummings

Neil Carter Inquest - Regulation 28: Report to Prevent Future Deaths

I am writing in response to your Regulation 28: Report to Prevent Future Deaths dated Wednesday 5 March 2014. Your report arises from the inquest into the death of Mr Neil James Carter, which concluded on Thursday 5 December 2013.

The matters of concern that you have raised under Regulation 28 are as follows:

1. There were repeated failures to perform basic nursing observations.

2. You heard evidence that indicated an enduring situation where the ward frequently had inadequate numbers of staff with an inappropriate skill mix and with an inappropriate lay out over two floors. There was a lack of discipline with staff failing to accept a nurse in charge's authority. You have stated that management were informed of some issues but failed to listen or act.

3. There was a deliberate falsification of the nursing record.

You have exercised your powers under Regulation 28 by issuing this report and indicating that action should be taken to prevent future deaths.

Applying the above numbering:

1. In response to points one and three, I understand that the records falsification and a number of key missing observations in Mr Carter's case for the afternoon he absconded from the ward, fell to one nurse. I am informed that the relevant individual was disciplined through Priory's internal processes and dismissed from employment. She was also referred to the NMC as her actions fell short of the standard required.

   We recognise, however, that we should strive to improve compliance with observations and the documentation of those observations in accordance with the risk assessments undertaken. In respect of staff carrying out patient observations, I am informed that these improvements have included changes to the staff induction programme at Roehampton and better registration and monitoring of patients at ward therapy groups. There has also been a review of the overarching Priory Group Healthcare Division Observation and Engagement Policy.

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To support compliance, standards across Roehampton Hospital are also monitored internally through the use of Healthcare Division 'Quality Walk Rounds' which are undertaken on a weekly basis and operate to a set four-week rolling programme of monitoring. For example, week one involves an assessment of the environment and week two involves an assessment of patient care which includes a review of the completion of patient observations and care plans.

The Quality Walk Rounds, which were introduced in September 2013, are undertaken by staff external to the particular ward (for example, a Ward Manager from another ward together with members of the Roehampton management team). The results of the Quality Walk Rounds are reviewed at the monthly Roehampton Hospital Clinical Governance Meetings. These meetings are chaired by the Roehampton Hospital Director and attended by representatives of the medical and therapy teams. Where improvements are required, these are recorded and monitored.

2. In point two you state that '.... the ward frequently had inadequate numbers of staff with an inappropriate skill mix and with an inappropriate layout over two floors...'

   I am informed that following Mr Carter's death, Garden Wing was separated into two distinct wards. Each ward has its own ward manager and nursing team together with therapists and activity co-ordinators. I am informed by the hospital that the two smaller wards are sufficiently staffed and that the managers and nursing staff of the wards are sufficiently skilled and experienced. The wards are supervised by the Roehampton Hospital Director and additional clinical support is provided by the Clinical Services Manager. They will continue to monitor staffing levels and skill mixes to ensure they are appropriate.

   You also are concerned that: 'There was a lack of discipline with staff failing to accept a nurse in charge's authority'. I understand this arose from the experience of one nurse giving evidence at Mr Carter's inquest, who had found that certain individuals had not respected her more senior role. We of course accept that such a situation is unacceptable and whilst there may be differences of opinion between members of staff, I am informed there is now much more emphasis at Roehampton Hospital on there being an effective framework of supervision and appraisals so that the risk of issues in relation to authority can be identified more rapidly and managed. Further, I understand there is now a local Human Resources function at Roehampton Hospital with trained staff who can provide faster support and advice to those with staff management responsibilities who may feel their authority is being challenged.

   You also state that: 'Management was informed of some issues but failed to listen or act'. In order to facilitate communications between management and staff, I am informed the following are now in place at Roehampton Hospital:

   - Daily monitoring visits have been embedded across the hospital. These visits are undertaken to each ward by either the Hospital Director or the Clinical Services Manager as a means of checking patient care and responding to any immediate concerns expressed by staff.

- The introduction of a daily 'flash' meeting which is held every weekday morning attended by the nurse in charge from each ward, the hospital duty doctor and members of the hospital management team. The purpose of the meeting is to understand ward and hospital activity during the previous 24 hours/weekend and to plan for the forthcoming 24 hours/weekend.

- A monthly staff meeting which enables a broad cross section of staff to meet with the hospital management team and to both provide and receive feedback on safety, quality and compliance within their area.

In addition to the issues you have raised, I would also like to advise you that the Priory Group has a dedicated team of experienced compliance inspectors who undertake a rolling programme of detailed compliance inspections. The compliance inspections audit standards over and above those standards audited by external regulators. These internal inspections act as an early warning system to inform divisional and hospital management if improvements or adjustments are needed to be taken in relation to patient care.

I hope that this response provides you with sufficient assurance in respect of your concerns but please do not hesitate to contact me if I can be of further assistance.

Yours sincerely,

Tom Riall
Chief Executive Officer
Priory Group

Copy to: [redacted] Director of Safety for further managed circulation.