A teaching trust of Brighton
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[redacted]

8 October 2013

CONFIDENTIAL

Mr Christopher Wilkinson
Assistant Coroner
Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
PO19 1DD

Dear Mr Wilkinson

Re: Inquest into the death of John Leon Naylor Walker – 21 May 2013

Thank you for your letter of 22 August 2013, concerning the Inquest into the very sad death of John Walker, and your subsequent Regulation 28 Report.

We have now had an opportunity to consider the four areas of concern you have highlighted.

1. Risk care planning

It is difficult to respond definitively to your conclusion that the consideration of, contribution to and preparation involved in risk care planning for Mr Walker was insufficient. We do acknowledge that some documentation was not of the standard we would expect. In particular, the Risk Care Plan and the Formulation section of the MDT Clinical Review was poor and so taking this in isolation could imply insufficient risk care planning. However, I think it is important to reinforce the evidence of [redacted] Consultant Psychiatrist. She explained that the staff caring for Mr Walker did have a good understanding of his risks and that these risks were documented in the Acute Care Risk Assessment, Acute Care Screening and the daily MDT Evaluation and Progress Notes.

The point I think you are making is that the identified risks should also have been included in subsequent documents, such as the Risk Care Plan. We completely agree. As I say, the Risk Care Plan for Mr Walker was poor. In recognition of the importance of documentation and to ensure continued learning and improvement, we have since revised the documents clinicians are asked to complete. This is to ensure they are less repetitive and better support succinct recording of relevant issues. Regular audits are completed to ensure adequate standards are met.

In relation to how the risk care planning might have affected the decision about observations, again, I refer to the evidence given by [redacted] She explained that Mr Walker's risk of impulsivity and low mood was carefully considered and that this was why he was nursed on intermittent, every 30 minutes, observations, which is an enhanced level. This was to encourage engagement and to more closely monitor his mental state. Although Mr Walker was ambivalent about the future, he was making some plans and expressing a will to recover. He did not have any history of attempting to harm himself while in hospital, and nor did he

ever try to abscond. This was of significant clinical importance to the treating team when assessing which level of observation was appropriate.

Reflecting on the information available to them at the time, the clinicians involved do not believe a different level of observation was clinically indicated.

2. Documented rationale for the observation level

We acknowledge that the rationale for changing the level of observation was not documented. The expectation is that this must be written down and this is what is stated in the policy. This is very important and our Nurse Consultant has provided training to staff to help ensure this happens more consistently.

The point you make about the absence of documented rationale when observation levels do not change is a slightly different issue. Firstly, the use of observation to provide support and to manage risk is something clinicians consider constantly, and so we would not always expect the rationale to be recorded during periods when the level remains the same. This would only be necessary when there is a significant change in risk, as determined by clinical staff.

When reading Mr Walker's records in isolation and with the benefit of hindsight I can see why it may appear as though his risk was changing and I think you probably have in mind the last Ward Review when he stated that he had never felt worse. Once more I refer to the evidence of [redacted] when, in relation to this last review, she explained this comment was in the context of wanting to start Lithium and was made early on in the review. By the end he appeared more positive and was very much involved in the decisions about his care [redacted] was aware that there were times when Mr Walker was expressing suicidal thoughts, but he also stated feeling safe on the ward and never expressed to staff a wish to leave even though he was in hospital voluntarily. It was therefore completely unexpected when he absconded, especially in the way he did.

3. AWOL

Staff contacted the Police within 50 minutes of them noticing that Mr Walker was missing. This was after a full search of the ward, hospital, and hospital grounds was conducted, and after attempts were made to contact Mr Walker and his family. It was also the conclusion from our internal investigation that the AWOL policy was implemented appropriately.

4. Fences

Opal Ward at Langley Green Hospital is an open ward and so there is no requirement to have fences at a particular height, as would be the case for a secure unit. Had Mr Walker or any other patient at that time been considered a risk of absconding then staff would have taken steps to ensure appropriate supervision; this may have included locking the door to the garden. As you know, the fences throughout Langley Green Hospital have been subsequently altered to make it much more difficult to get over. This was done in order to make it possible to always keep the doors to the garden open, as this promotes a more therapeutic environment. Absconding in the way Mr Walker did we believe was not foreseeable, for the reasons already set out.

Mr Walker's death came as a shock to all the staff involved in his care. Please be assured that each one has taken time to reflect and consider the issues that have arisen, including the concerns you have highlighted.

I hope this reply is helpful.

Yours sincerely

Lisa Rodrigues CBE
Chief Executive