Devon Partnership NHS
NHS Trust

COPY

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Your Ref: JGT/RCB File No: 365/2015

14 December 2015

Mr J G Tomalin
Deputy Coroner
Exeter and Greater Devon Coroner's Office
Room 226
Devon County Hall
Exeter
EX2 4QD

Dear Mr Tomalin

Re: Diane Knight (deceased) – DOD 03/02/15 - Inquest 3 to 7 October 2015

Regulation 28 Report to Prevent Future Deaths

Thank you for your letter of 22 October 2015 which we received on the 23 October 2015 following the inquest into the death of Diane Knight. As an organisation we are committed to learning from these tragic events and have since receiving your report and recommendations taken the opportunity to share your findings with the service involved as well as across the wider trust.

The Trust has undertaken a Root Cause Analysis Investigation following the death of Diane Knight; the report is currently in draft form and has been submitted to our commissioner for review and approval. A copy of the draft report has been included for information, however this may be subject to further changes once the commissioner has reviewed the report. The draft report has not yet been shared with the family. We will be sharing the report with the family once the commissioner has approved it and we would be happy to forward a copy to you at the same time.

The Root Cause Analysis report contains two recommendations; both of which were accepted and the actions are being progressed.

Recommendations from the Root Cause Analysis report

(1) The practice of patients obscuring/covering the glass windows in their bedroom doors will be discontinued across all inpatient areas within Devon Partnership NHS Trust. A patient safety alert will be issued highlighting the risks and the actions required to be taken to eradicate this risk.

(2) Clinical Governance systems across the Adult Directorate will be used to disseminate and share this report and its findings with clinical staff across the wider Adult Directorate in order to promote reflective considerations and discussion.

The investigation and report has identified a specific recommendation and actions that will address the concerns you raised, and this is detailed further below.

(1) The continued practice of putting a towel over the door could hide an attempt by a patient to harm themselves or end their life as here with a belt end being trapped by the door against the door jamb.

(2) The continuation of this practice may prevent staff being properly able to monitor the patients on the unit; therefore this practice should be reviewed.

Following discussion and review with the clinical team directly involved in the care of Diane Knight as part of the Root Cause Analysis process the historical practice of covering the bedroom windows with a towel to minimise light intrusion has been discontinued.

A trust wide safety briefing has been produced and was published on our Trust intranet, this is accessible to all staff and is one of the ways in which we publish and share learning across our services. This briefing was also included in our 'on-line news' which is sent out by email to all staff.

The briefing stated -

'*The Trust has received a Rule 28 from the Coroner in relation to the continued practice of putting a towel, or any other item likely to prevent staff properly observing or monitoring the patient through the window of bedroom doors (to stop light intrusion), as there is a risk that putting a towel or similar item over the door could hide an attempt by the patient to harm themselves or end their life such as in this particular case. The alert applies to* ***all*** *inpatient areas across the Trust and* ***requires immediate action and compliance****.'*

A copy of the safety briefing is attached for your information.

We plan to issue a further local alert to all inpatient units which will be sent using our alerts process; this requires a formal response from each ward confirming that the alert has been reviewed and appropriate action taken. This is going to be sent once the RCA report has been agreed so any further actions from the commissioner's review can be included. **This is due to be completed by the end of January 2016** (following agreement of the report by the commissioner).

(3) An alternative method for preserving patient privacy should be considered that would now allow a patient to conceal an attempt to cause themselves harm.

The wards and individual rooms are designed to provide patient privacy whilst maintaining the ability to manage an individual's safety, however as in this tragic case, the practice of covering the observation windows; which are designed to be obscured when needed by means of a physical lever in the window has resulted in the patient being able to conceal themselves. and the implement used to assist in the suicide.

We are in the process of developing our Respect and Dignity Audit; we will be including a specific requirement for teams to consider how they maintain privacy in these types of situation and what more can be done to keep patients safe whilst maintaining their privacy. This audit will then inform any wider actions needed. **The audit is due to be completed by the end of January 2016**.

I hope that the actions described demonstrate our commitment to the learning we have undertaken. If you required any further information please do not hesitate to contact me.

Yours sincerely

Paul Keedwell
Director of Nursing and Practice

On behalf of Melanie Walker, Chief Executive