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enabling outstanding lives

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Dear Ms Crawford

Inquest touching upon the death of Miss Rebecca Gilbank
Regulation 28 Report to Prevent Future Deaths

Introduction

I refer to the above inquest and your subsequent Report to Prevent Future Deaths dated 26 July 2016 (the "**Report**"). I note that your conclusion at the end of the inquest was that Ms Gilbank's death was a result of Natural Causes and that the specific cause of death was Sudden Unexpected Death in Epilepsy.

Your Report contains two matters in respect of which you are of the opinion that action should be taken in order to prevent future deaths and you believe that I have the power to take such action. Please find my response to those two matters below.

Lack of check at 1.30am on 12 May 2015

Your Report states *"Evidence at inquest revealed that the check was not carried out because the two members of waking night staff were busy dealing with other service users. The court heard evidence that this was not an isolated occurrence and that checks had been missed on other occasions in circumstances in which staff were dealing with other service users. Consideration should be given to providing sufficient staff resources to ensure that staff are able to carry out the relevant checks at the times required."*

It is the responsibility of each local authority to assess individuals in its area who appear to be in need of care and support and to arrange a care and support package which meets those assessed needs. In the case of individuals who are eligible for NHS continuing healthcare, the local authority should work with the relevant clinical commissioning group ("**CCG**"). The services provided by Independence Homes to Ms Gilbank were funded by Havering CCG on the basis that Ms Gilbank would be living in her own home Clareville Lodge with two waking night staff on duty each night. A review of the services provided by Independence Homes to Ms Gilbank was conducted on behalf of the CCG on 26 February 2014 and no issues were raised. Furthermore no concerns were raised by her consultant or GP, who were aware of the staffing levels. If

at any stage any issues had been raised with us as to the staff resources available, we would have been happy to discuss provision and funding with the CCG. I note that none of Independence Homes' service users receive funding for a higher staff ratio but we would be happy to provide this at the request of a funding authority.

Independence Homes uses a bespoke alarm system and employs waking night staff at each of the locations at which it provides its services. Depending on the number of service users living at each location and their level of need, there will be between one and three waking night staff. As you heard during the inquest, there are two waking night staff at Clareville Lodge between the hours of 9:30pm and 7am. Waking night staff are required to complete biometric night swipes every 30 minutes during their shift. These biometric swipes ensure that the staff on shift during the night are awake on duty overnight. As far as I am aware, this goes well beyond the service provided by other specialist epilepsy providers, whose staff are not required to complete biometric night swipes. Independence Homes also has a waking night manager (who works approximately 4/5 nights per week) whose role is to advise, supervise and manage the waking night domiciliary care teams across the locations that Independence Homes provides services and to conduct spot checks on services. Medical and operational staff are on call each night.

There are no guidelines as to how often individuals with epilepsy should be checked during the night, nor any guidelines as to how often checks should be conducted in connection with the provision of domiciliary care. However, there is evidence that sleep deprivation from sleeping night checks can make seizures worse (as noted in our letter of 11 April 2014 to Debbie Gilbank and also sent to the parents / carers of other service users). In general and noting that there is variation in respect of individuals' care plans, Independence Homes' service users usually have checks which are carried out by waking night staff on an hourly basis. It is not as a result of a legal requirement or guideline that checks are carried out but based on our judgement of their care needs. The purpose of these checks is to check service users' general wellbeing. Our waking night staff rely primarily on the bespoke alarm system to detect if a service user suffers a seizure. Waking night staff are trained to respond to an alarm as a priority. As noted above, Independence Homes has its own bespoke alarm system and as far as I am aware, this goes well beyond the service provided by other specialist epilepsy providers, who may *either* rely on waking night staff or on sleeping night staff and the benefit of assistive technology. I am unaware of any other service that has waking night staff (each of whom is monitored remotely by biometric swipe) as well as bespoke alarms on service users' beds.

In terms of staff resources for providing hourly checks and responding to other service users' non-emergency needs, there will always be an element of prioritisation as no service user receives one to one care at night. While we would expect our waking night staff to carry out their scheduled checks wherever possible and in the majority of cases, we accept that there will be occasions where hourly checks will have to be delayed or missed where one or both members of staff are providing support to another service user(s) at that time. The daily delivery plan is completed throughout the day and night and our processes require the team supervisor to check it at the end of each shift to ensure the relevant information has been recorded, including in relation to checks. The next morning it is expected that the manager will check the plan, which should also include consideration of whether checks have been completed. If a check has been missed or delayed, the manager would be expected to speak to the member of staff and

investigate why the check was not completed. If an hourly check is missed or substantially delayed we would expect the waking night staff member responsible to be able to provide an explanation as to why that check was missed and to evidence what support they were giving elsewhere at that time as well as how quickly they resumed checks thereafter**.** In addition, a monthly quality assurance review is conducted by Independence Homes' Operations Co-ordinators; part of that review involves checking whether daily delivery plans have been delivered appropriately. Independence Homes has also made arrangements for family members of service users to go into services once a month to conduct spot checks. We note that an alarm should always be responded to as a priority, even if some form of care or support is being provided to another service user at that time.

We have considered the staff resources that are available at our services during the night. We believe that sufficient waking night staff are made available at our services. If an individual's assessed needs mean that they require one to one support or a higher ratio of waking night staff to service users, we note that it is the responsibility of the local authority or CCG to arrange a care and support package which meets those assessed needs and to fund it appropriately.

Lack of knowledge about how to obtain an outside telephone line

Your Report states *"Evidence at the inquest revealed that the staff on duty did not know how to obtain an outside line to call emergency services and, after trying, had to rely on a personal mobile phone. This resulted in a delay of unknown duration. Consideration should be given to providing clear and accessible guidance to all staff, including staff who do not work at Clareville Lodge on a regular basis, to ensure that they are aware of how to obtain an outside line in the event of an emergency."*

I note that, at the time of Ms Gilbank's death, clear and accessible guidance on how to obtain an outside line was provided, I understand that there was a sign on the noticeboard in the staff office at Clareville Lodge which stated that staff should dial 9 for an outside line.

Independence Homes has taken action in relation to this matter. At a meeting on 14 July 2016, at which we considered the evidence provided during the inquest, we immediately sought to rectify the issue of dialling 9 for an outside line from some of our locations. On 26 July 2016 we contacted our telephone provider and we changed our contract so that there is no longer a need to dial 9 to obtain an outside line. This change was communicated to staff verbally, by email on 7 September 2016 and in the Clareville Lodge Communications Book. Please find a copy of the email enclosed.

Conclusion

I hope that the information in this response provides assurances that Independence Homes has taken action, where it has the ability to do so, to prevent future deaths.

Yours sincerely

[redacted]

[redacted]

Medical Director