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13 February 2019

Private and Confidential
Senior Coroner ME Hassell
Inner North London
St Pancras Coroner's Court
Camley Street
LONDON N1C 4PP

Dear Coroner Hassell

Re: Prevention of future deaths report - inquest concerning the death of Agnes Stephanie Lambert

I am writing further to the conclusion of this inquest that took place on 17 December 2018 and the subsequent Prevention of Future Deaths report that was issued to the Trust.

Agnes Lambert was employed by the Trust as a mental health nurse based at Highgate Mental Health Centre. In the months prior to her death, an issue had arisen in regard to a patient who had become fixated on her and it was alleged that she had entered his room at night without telling other members of staff. A disciplinary investigation was commissioned and Ms Lambert was informed on 12 April that the case would proceed to a formal hearing. At this point, Ms Lambert went on sick leave, returning to work on 19 June, following the disciplinary hearing which took place on 29 May 2018. Ms Lambert's death was reported to the Trust on 2 July 2018. The matters of concern that arose from the inquest were as follows:

1. Prior to the allegations of Ms Lambert entering the patient's room, a more senior staff member recognised the patient's fixation and requested that she be temporarily redeployed to work on another ward. She declined and the manager did not insist on this redeployment. At the hearing, the Senior Service Manager who gave evidence,

accepted that the temporary redeployment to another ward should have been made regardless of Ms Lambert's wishes. If this had been executed, she would not have been in a position to enter the patient's room later.

2. Following the allegations, the investigation process took four months to interview eight witnesses in order to progress to a disciplinary hearing. This was obviously a distressing time for Ms Lambert and at the point that the decision was made to progress to a hearing, she went on sick leave. The Senior Service Manager who gave evidence in court agreed that the lengthy process was unacceptable.

You requested that we respond by 18 February 2019 to inform you of our intended actions.

Thank you for highlighting these issues which have subsequently been discussed and reflected on at a number of forums between the operational teams involved and HR & OD. We are committed to learning from Ms Lambert's tragic death and promote to staff that the Trust is a just and fair place to work.

Firstly, it is recognised that at the time that these events began, the ward where Ms Lambert worked did not have a permanent ward manager in post and the overall management and supervision structure on the ward was not as robust as it should have been. Significant steps have since been taken to address this and there is now a permanent ward manager. Further, we have recognised that there is a general need among managers for further support around how to have challenging conversations with staff, particularly in situations such as this, where the intention is not to punish the staff member, but to ensure their safety, whilst making it clear that staff are expected to follow reasonable management instructions. To support this, we are in the process of rolling out 'vital conversations' training which will form part of the professional requirements for all line managers in the Trust, though nursing managers will initially be prioritised.

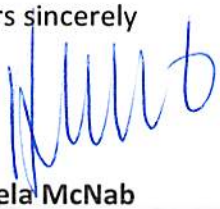
We absolutely recognise that unnecessary and lengthy disciplinary processes can have a serious detrimental impact on staff mental health and wellbeing. With this in mind, the disciplinary policy is currently being reviewed to include clearer criteria as to what does or does not warrant a full investigation. We also have an added step in our disciplinary process whereby a specially-trained lay member of staff reviews cases to gain assurance or indeed challenge that a formal hearing is required. It is expected that this change along with the

Vital Conversations training, will facilitate more issues being resolved informally through the supervision process. For those investigations that do proceed formally, there will be a greater focus on managers' responsibility to minimise delay/keep to timeframes, and monitoring to ensure that managers have offered/referred staff to occupational health for support and also made them aware of our Employee Assist Programme. The refreshed policy is expected to complete in March 2019.

The risks posed by unnecessary and lengthy disciplinary processes have been added to the HR & OD department risk register to monitor and ensure progress is made.

I hope that my response provides you with the necessary assurance. If you need any further information please do not hesitate to contact me.

Yours sincerely



Angela McNab
Chief Executive