NHS
South Tyneside and Sunderland
NHS Foundation Trust

[redacted]

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20 January 2022

Private & Confidential

Miss Karin Welsh
HM Assistant Coroner for the City of Newcastle upon Tyne
Civic Centre
Barras Bridge
NEWCASTLE UPON TYNE
NE1 8QH

Dear Miss Welsh,

Dear ~~Miss~~ Welsh

Regulation 28 Report to Prevent Future Deaths – Mr Edward Cockburn

I write further to your correspondence dated 10th December 2021 regarding your concerns identified during the Inquest into Mr Cockburn's death.

As you are aware, "falls from poorly restricted windows", are classed as Never Events, therefore, constitute Serious Incidents (SI). Prior to the inquest the incident was fully investigated by the Trust and reported to the Police, Health & Safety Executive (HSE), Care Quality Commission (CQC), Sunderland Clinical Commissioning Group (SCCG) and Safeguarding Adults Team.

Our internal investigation identified omissions in care with regard to the level of observation in place for Mr Cockburn and the lack of escalation of concerns around staffing levels. Immediate actions were undertaken to address these issues, along with remedial estates work to fit additional window restrictors and swipe card access to restricted areas in key areas across the Trust, which has now been completed.

At the inquest hearing, you heard evidence from one of the witnesses that staff appeared to be unaware of the Trust Enhanced Care/Observation Standard Operating Procedure (SOP)[1] that was in place at that time. I would like to take this opportunity to inform you that this SOP was updated in December 2020 and is now entitled "Guideline for Enhanced Interactive Care and Observation (EICO) for Adult Inpatients".

[1] A tool utilised to ensure staff maintain an environment which is safe and reduces the risk to patients and others by providing heightened levels of observation for patients within stated criteria.

You also heard evidence from another witness that training at that time had not been given to all relevant members of staff in connection with the *SafeCare* electronic staffing tool[2].

Whilst information and training materials for both tools had been cascaded to staff when they were first introduced, there was no process in place to monitor that staff had accessed the information and training materials.

You have identified the following action required to avoid future deaths:

(a) Create a procedure to record details of training delivered, when and to whom; and
(b) Create a system to audit that procedure so as to ensure that all training has been delivered to all staff.

We have now agreed a mechanism to address these actions by utilising our existing Electronic Staff Record (ESR) system. We are developing E-learning packages for both SafeCare and EICO which will be uploaded to the ESR and easily accessible to staff. Staff who require this training will have an associated competency added to their learning profile and compliance matrix within ESR. This will allow the creation of reports to capture and monitor/audit completion of this E-learning at an organisational level, as well as a ward/department level.

I would like to assure you that this work is progressing well and we intend to utilise this model to monitor the training achievements when other new training programmes are introduced.

As you will note, the Trust is addressing the shortfalls highlighted during the Inquest, in order to prevent future deaths in similar circumstances. Progress of the actions detailed in this letter will be overseen by Melanie Johnson, Executive Director of Nursing, Midwifery and Allied Health Professionals, who will also keep me briefed and report progress monthly to the Trust's Governance Committee.

I trust this information provides assurance to you that the Trust has taken appropriate action to address your concerns with a view to improving patient care and safety and reducing the risk of any similar adverse incidents in the future.

I would also like to take this opportunity to offer my sincere condolences to Mr Cockburn's family on behalf of myself and the Trust.

Yours sincerely

[redacted]

Chief Executive

[2] A tool utilised to help determine safe staffing levels by matching staffing levels to patient number, acuity and dependency of patients in real time.