East London
NHS Foundation Trust

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Private & Confidential

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12 May 2022

Dear Madam

This is a formal response to your Regulation 28 report, received on 21 March 2022, in which you set out your concerns relating to the care of Gary Ottway whilst under the care of East London NHS Foundation Trust's (**the Trust**).

I understand that you heard evidence at the inquest on 11 March 2022, from the Trust's serious incident reviewer outlining the learning that has taken place due as a consequence of Mr Ottway's death. However, you remain concerned about the risk of future deaths in relation to the following areas:

> *1.Though Mr Ottway was meant to be under constant nursing observation, not only was he in cardiac arrest but he was also cold and exhibiting hypostasis when he was found. This appears to indicate that either the nursing observation was not constant, or it was not effective. I appreciate that the Trust is putting in place a new IT system to monitor signs of life, but nevertheless basic nursing observations must be performed competently.*
>
> *2.When the senior duty nurse and the nurse undertaking continuous observation noted that they could not see evidence of respiration, they did not immediately enter the seclusion room where Mr Ottway lay, because they deemed that unsafe following his earlier violent behaviour.*
>
> *3. The senior duty nurse told me at inquest that he could not be sure that Mr Ottway was not holding his breath, though he had never done this and there was no evidence that he was doing so now.*
>
> *4. The senior duty nurse also told me that the visibility through the Perspex panel was poor, though he had never brought this to anyone's attention and did not do so after Mr Ottway's death.*

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5. The senior duty nurse told me that the nurses would not enter the seclusion room until the rapid response team was present, but he did not call the rapid response team as soon as he suspected that Mr Ottway was not breathing. Instead, he started by going to get one of the other nurses, which took a couple of minutes; then he rang the duty doctor; and only after that did he radio for the rapid response team.

6.The junior doctor was the last person to attend the resuscitation and told me he did so after the rapid response team, yet no one had entered the seclusion room by the time he arrived. It may be that there was a (perhaps unconscious) reluctance to enter the room without a doctor, despite the presence of the rapid response (nursing) team. But by the time the junior doctor got to the door and immediately identified that Mr Ottway was not breathing, at least six and a half to seven minutes had elapsed since the first two nurses saw no evidence of respiration. This was well outside the three to four minute window of opportunity for resuscitation without inevitable brain damage or death.

7. In the six and a half to seven minutes before the junior doctor arrived at the seclusion room, the emergency grab bag had not. That took another 30 seconds, though to retrieve it was only a three minute round trip from the room where the nurses who had first identified the lack of respiration were waiting.

8. The junior (and only) doctor called to assist in the attempted resuscitation was not familiar with the contents of the emergency grab bag, told me that it would not have occurred to him to ask for any equipment to assist with ventilations other than a pocket mask, and explained that he was not trained in giving adrenaline or any other medicines for resuscitation. As he was the only medical resource available in the case of an emergency, these seem significant gaps.

9. When paramedics arrived, they found that chest compressions were being given (by nursing staff) to Mr Ottway's abdomen instead of his chest, thus rendering them ineffective.

I wish to assure you and the family of Mr Ottway that the Trust has reviewed the issues you highlighted, and has and will continue to undertake learning surrounding these topics. I outline the Trust's actions in relation to each of your concerns below.

NURSING OBSERVATIONS (Point 1)
At inquest, you heard oral evidence that Mr Ottway was under continuous nursing observations. The SI reviewer stated that those observations were undertaken appropriately and in line with the Trust's seclusion policy. The evidence that Mr Ottway was suffering from hypostatsis had not been provided to the SI author and, therefore, did not feature in the SI review. Since receiving your report, the Clinical Director of Tower Hamlets has reviewed this information and is investigating this further to see if further action is required.

A refresher session on effective observations for service users in seclusion will take place on the next away day on 19 May 2022 for Rosebank Ward, 26 May 2022 for Millharbour Ward and 20 July 2022 for all DSNs.

I understand that you heard evidence that the Trust is putting in place a new system called Oxehealth in order to monitor signs of life in the seclusion room. I am pleased to update you that this will be completed by the end of June 2022.

As a consequence of Mr Ottway's death, Tower Hamlets Directorate made the decision to have CCTV installed in its seclusion rooms. This has been completed and a live stream is now available for the seclusion rooms.

The addition of both Oxehealth and CCTV to the seclusion room will provide an additional layer of safety for service users in the seclusion room. While it will not replace nursing observations (and is not intended to), it will be a valuable adjunct and will improve patient safety overall.

SECLUSION ROOM ENTRY (Point 2,6)
I understand that the Trust Clinicians provided evidence at inquest that MAPA training requires a certain number be present prior to entering the seclusion room, especially if a service user is behaving violently. This is indeed the case, and it is the Trust's view that in light of this guidance, the relevant clinicians' actions were appropriate. Clinicians must be able to keep themselves safe if they are to effectively care for service users. Both the installation of Oxehealth and CCTV will be a helpful adjunct to managing the seclusion room for this reason.

It is unfortunate that the Trust's seclusion policy does not currently clearly state this. However, it is being updated to reflect this and to include specific guidance for dealing with medical emergencies. This will be completed by August 2022.

PERSPEX PANEL VISIBILITY (Point 4)
The Perspex panel has been replaced and is now clear.

EMERGENCY RESPONSE (Point 5,7,8,9)
Weekly emergency response simulations are now held across Tower Hamlet's in-patient wards.

A quality improvement project has been started with the goal of ensuring that the emergency simulations are robust and provide the necessary learning and education to clinicians.

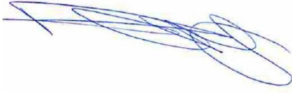
In cases of a suspected clinical emergency, clinicians should either raise the alarm or call the rapid response team for assistance via the radio – immediately. This is reflected in the simulations. The new guidance on medical emergencies in the Trust's seclusion policy will also make this clear.

The Trust's junior doctors are now included in all of the emergency response simulations. A session has been added to the junior doctor induction for the purpose of familiarising them with the contents of the grab bag and how to use the equipment.

The simulations include a focus on good quality CPR. Recent feedback from paramedics has confirmed that the standard of CPR across the directorate is significantly improved.

I hope this response assures you and the family of Mr Ottway that the Trust has fully considered and addressed your concerns.

Yours sincerely



Dr [redacted]
Chief Medical Officer