

Ms G Brannigan
HM's Assistant Coroner for Buckinghamshire
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Chief Executive's Office
Trust Headquarters
Littlemore Mental Health Centre
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20th April 2022

Dear Ms Brannigan,

Inquest into the death of Amanda Gibbens

Thank you for your report dated 23 January 2022 following the conclusion of the inquest into the very sad death of Amanda Gibbens. Once again, I extend my own and the Trust's deepest condolences to Amanda's family for their loss.

Thank you for sharing your concerns with me regarding two matters. I shared your report with senior colleagues at the Trust. I now respond as follows -

Concern 1: Using a monitor screen for Level 3 constant "within eyesight" enhanced observations

The actions that the Trust are taking are –

- 80% of Level 3 observations are in locations where there is no monitor. As you heard in evidence, a monitor was in use at the de-escalation room. The monitor in the de-escalation has been isolated in order to prevent staff from using it when a patient is in the de-escalation room and the patient is being nursed on Level 3 eyesight observations. *Isolated* means that, when the room is being used as a de-escalation room, the monitor is sealed off/disabled and cannot then be used by staff. In the event that the room is used for seclusion, which is rare, a request must be made in order to enable the monitor for use. The request will go to the Estates service via the ward manager or modern matron.
- The Trust's Safe and Supportive Observations policy is being reviewed to reflect the prohibition of the use of monitors for Level 3 eyesight observations in the de-escalation suite.

- Local induction and training for all staff is in place in order to cascade the changes to Trust policy on the use of the monitor in the de-escalation suite.
- Re-assessment of all staff competencies on safe and positive observations are being completed annually. This annual competencies review is a new addition.
- We are reviewing the induction and handover for agency and temporary staff as part of the new practice to prohibit the use of monitors for Level 3 eyesight observations in the de-escalation suite.
- Our Chief Nurse is coordinating a South East region Director of Nursing group to review policy and practice across the region in relation to observations in mental health settings – any learning from this will be used to inform our own Trust policy

Concern 2: Searching bedrooms on Ruby ward for prohibited items

The Trust has a search policy that records the when to search patients and their property when they are inpatients. The policy applies to detained patients and informal patients.

It may be that there has been a potential conflation of the use of the terms *searches* and *checks*.

A *search* is subject to the Trust's search policy. A search of a patient and their bedroom will be determined by the patient's risk assessment. A search is an intrusive event and under the Mental Health Code of Practice and guided by CQC regulations, regulated providers must not apply blanket policies to practices such as searches. A search is a robust and detailed examination of every item, belongings and area in a consistent and mechanistic way. A search may take place when, for example, a patient returns from leave if it is deemed on the balance of risk as appropriate action to take. A *search* may also take place of a patient's room in order to seek out a missing item that may jeopardise individual safety or the general safety of those on the ward. This again is a decision determined an on individual basis.

A *check* is a routine exercise in which staff assure themselves that there are no items in a room or on the ward that should not be there. This is part of everyday practice in order to identify if prohibited items are present. That is, staff are checking the environment in order to identify if there are prohibited items present. As you will appreciate, staff are constantly on alert for the presence of any prohibited items on a ward.

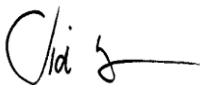
The Trust's policy *Search of Patients and their Belongings* is due for review in July 2022 as part of the Trust's governance. We will strengthen the Trust's policy with the following actions:

- Re-visit the policy in order to be sure that the policy sets out clearly the best practice required by the Trust in relation to both searches and environmental checks.
- The policy will form part of induction for all new staff joining the ward team.

- Review the practice of environmental checks on wards. We are consulting with the modern matrons as part of the review.
- Develop a local search flow chart which provides a clear guide to the Trust Search policy and which indicates when and how searches of patients and bedrooms should be conducted, including the frequency.
- Provide an induction programme for all staff to deliver the new search flow chart once developed.
- Share and communicate the new search flow chart to all mental health inpatient wards within the Trust.

As you heard at the inquest, the Trust completed an extensive investigation following Amanda's death. That investigation was carried out in order for the Trust to identify recommendations and actions as promptly as possible. The Trust identified a number of actions through that investigation and I understand that you received evidence about those actions. You were able to identify two further points of concern through the extensive evidence that you received at the inquest and I hope that this information provides you with assurance that the Trust is taking appropriate actions in response to your concerns.

Best wishes,



Dr [REDACTED]
Chief Executive