East London
NHS Foundation Trust

Office of the Interim Chief Medical Officer
Trust Headquarters
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Private & Confidential

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21 July 2022

Dear Sir

RE: Regulation 28 Response for Mr Ian Cockfield

This is a formal response to your Regulation 28 report dated 25 May 2022 in which you set out your concerns relating to the care of Ian Cockfield whilst under East London NHS Foundation Trust's (the Trust) care.

I understand that you heard evidence from the Trust's Serious Incident (SI) Review author and the Borough Lead Nurse for Newham at the inquest on 24 May 2022 outlining the learning that has taken place as a consequence of Mr Cockfield's sad death. However, you remain concerned about the risk of future deaths in relation to the following area:

"On Sunday 11th July 2021, Mr Cockfield was discharged from the hospital after treatment. The patient was discharged to a different mental health hospital. Upon arrival at the mental health hospital at 1600 hours, a review of the patients falls risk assessment was not undertaken. The following day, Mr Cockfield suffered a fall whilst mobilising, unsupervised by staff. Mr Cockfield sustained a serious laceration to the head."

I wish to assure you and the family of Mr Cockfield that the Trust has reviewed the issues highlighted and taken actions as outlined below.

Serious Incident (SI) Investigation Evidence

Serious Incident Findings

I understand that you heard oral evidence at inquest from the Trust's SI author, and the Trust's Borough Lead Nurse for Newham that there were a series of systems issues surrounding Mr Cockfield's admission that led to missed opportunities in his care, including that a falls risk assessment did not take place within 24 hours as per the Trust's physical healthcare policy.

A summary of the Trust's SI review findings is as follows:

- Mr IC was transferred from Royal London Hospital (RLH) to Topaz Ward at Newham Centre for Mental Health (NCFMH) over the weekend. A transfer was agreed for 11 July 2021 and he arrived on Topaz at 15:58 pm.

- It is important to note that it is unusual for weekend transfers to take place for complex cases due to lower numbers of senior staff members on the wards at that time.

- Upon arrival, Mr IC's admissions clerking was delayed as the records from Globe Ward, Mile End Hospital where he was an in-patient prior to his stay at RLH were not available for several hours which delayed the admissions process.

- The SI review found that not all staff were aware of how to access records from other wards.

- Mr IC was eventually admitted at 19:20 pm by a junior duty doctor. He completed comprehensive admission notes, although a NEWS 2 score was not completed.

- Subsequently, a falls risk assessment was not completed within 24 hours of admission and 15-minute observations were not commenced.

- Mr IC subsequently fell at 18:00 on 12 July 2021 and suffered a laceration to his head. He was taken to RLH A&E at 20:45pm.

The Trust's Serious Incident (SI) investigation identified the following missed opportunities: 1) A NEWS 2 score was not completed; 2) a falls risk assessment was not undertaken in line with the Trust's physical healthcare policy and 3) 15-minute observations were not commenced as per the ELFT observation policy. The SI review found that these errors were related to this having been a weekend transfer from a medical ward to a mental health ward of someone with complex physical health problems.

SI Actions

The following actions were taken by the Trust to ensure that the learning from this incident was embedded into the Trust's policies and processes:

All weekend transfers of inpatients from acute hospitals now require senior management approval and a consultant-to-consultant handover. This ensures that there is a comprehensive management plan in place which is communicated to all staff in relation to out of hours transfers.

All Friday, Saturday and Sunday admissions are reviewed in a weekend huddle. The outcome is shared with on-call consultant, to ensure that patients with complex health needs are reviewed by senior medical personnel during that time.

Regular interface meetings with Barts Health NHS Foundation Trust have been taking place between the Trust's Deputy Borough Lead Nurse and Newham University Hospital (NUH)'s Director of Nursing. They have developed a process for escalating urgent matters (including weekend transfers). A draft Standard Operating Procedure will be ratified by September. Importantly, these meetings have already resulted in joint learning in other areas as well.

The psychiatric liaison team will cut and paste RLH physical health ward round information into the notes of complex patients so that pertinent physical health information is available immediately following transfer to mental health wards.

Current staff have been reminded that upon transfer back from an acute hospital, just like other new admissions, NEWS 2 scores must be undertaken in accordance with the ELFT admission policy. This has also been included in new staff inductions.

Staff have been reminded to undertake 15-minute observations upon transfer back from an acute hospital, just like other new admissions. This has been emphasized in induction and training. Observations audits are now undertaken on a weekly basis.

Daily Multi-Disciplinary Team huddles on the adult mental health wards in Newham have been opened to Occupational Therapists to ensure that falls risk assessments are being undertaken in more complex cases. There is a daily process of monitoring actions from the huddles which ensures the completion of the falls assessments that were identified to be undertaken.

The learning identified in this case has been shared with the other ELFT Directorates.

I am confident that this range of actions has helped to robustly address the issues surrounding complex weekend transfers from medical wards.

Additional Actions

As a consequence of your specific concern about the falls assessment not being completed, the Trust is reviewing its Physical Health Care Policy and its Slips, Trips and Falls Policy.

We have discovered that some of the information in the two policies is inconsistent. Whilst the former states that if there are concerns about mobility on admission a full moving and handling assessment should be completed and a falls risk assessment undertaken within 24 hours, the latter notes that only those older adults and those in younger age groups who are identified at risk of falls should be offered a falls risk assessment (with no specified timeframe).

Consequently, different staff members may have different understandings of when a falls risk assessment should be completed.

The Trust's Director of Nursing for London Mental Health Services, is reviewing and updating these policies within the usual governance frameworks for doing so. Going forward, they will provide clear and consistent guidelines for completing assessments for adult service users including timeframes clarifying all patients who require a falls assessment within 24 hours of arrival on a mental health ward and will also highlight special cases, where it should be done within a shorter time period. This will be completed by September 2022. Relevant communication about this update along with its incorporation into the physical health training sessions for nursing staff on adult mental health wards is expected to secure further improvements in this area.

I hope I have provided reassurance to you and the family of Mr Cockfield about the learning that has taken place following Mr Cockfield's sad death.

Yours sincerely

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Interim Chief Medical Officer

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