NHS
Central and
North West London
NHS Foundation Trust

Executive Office

2 December 2024

Mr Tom Osborne
Senior Coroner for Milton Keynes
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
MK9 3EJ

Dear Mr Osborne,

Re: Regulation 28: Report to prevent future deaths

Thank you for your Regulation 28 report dated 10 October 2024 following the inquest into the death of Florence Elizabeth Catherine Stewart on 23 January 2024.

Central and North West London NHS Foundation Trust deeply regrets the death of Ms Stewart and we would very much like to extend our condolences to Ms Stewart's family and friends.

I am writing to provide Central and North West London NHS Foundation Trust (CNWL)'s response to the concerns that you raised in that report.

You raised two matters of concern which I will respond to in order:

1. That the system of high-level intermittent observations failed to prevent Florence's suicide and needs a fundamental review.

The Divisional Directors have provided assurance that the Campbell Centre management team has implemented new systems and processes to support staff in applying the Trust Policy on Observation and Therapeutic engagement and have introduced measures to monitor understanding, training, and compliance. They have advised that there have been meetings with all staff to emphasise the importance of adherance to the Policy.

The specific themes from Ms Stewart's inquest have been discussed in group supervision, individual supervision and ward meetings. The Campbell Centre management team has strengthened how temporary and new staff members are inducted to ensure that they can better identify their patients' needs. They have also embedded a system to oversee staff uptake of training in the use of observations and therapeutic engagements.

The Nurse in Charge role has been realigned to ensure that the observation system is delivered to prioritise patients requiring high-level intermittent observations and oversee a seamless handover of care when alternating staff members. This includes faster escalation

in the event that a patient cannot be immediately located. Observation activity is a standing agenda item in ward safety huddles.

The Trust has fully embedded the use of the Brigid app, a hand-held device that allows staff to remain with the patient and enter real-time updates of observation records, automatically updating the Trust's clinical record system. This has been optimised since the inquest and enables staff to document the rationale and frequency of observations, including prompts for random checks.

The Campbell Centre management team has refined its governance processes to ensure that changes have been embedded. This includes several checks carried out during each shift by a duty senior nurse to ensure that observations are completed in time, a daily review by the MDT on those patients at most risk of harm, and senior nursing input allocated to support this.

A system of audit schedules has been revised to check for weekly improvement, this is led by a senior practice development nurse.

The Campbell Centre is part of a Trust-wide Quality improvement project looking to improve patient observation quality. The project commenced in November 2024 and is due to continue until May 2026

2. The Oxygen bottle used during resuscitation ran out of oxygen.

The Divisional Directors have confirmed that there is always an ample supply of oxygen across the Campbell Centre, which is easily accessible to trained staff. They have checked that all of our nurses are trained to conduct daily checks of the supplies and that temporary, or new staff members, receive an induction on oxygen availability before they start providing care.

The Campbell Centre management team has provided targeted training, including increasing the use of simulation exercises to improve familiarity with oxygen use, in addition to regular mandatory training in emergency life support.

Since the inquest, the Trust Resuscitation Group have developed a visual aid that is attached to each oxygen cylinder that clearly explains how to switch on the oxygen. In addition, a written communication highlighting this issue has been sent out to all Trust staff.

Thank you for bringing your concerns to our attention. I hope that this response provides some reassurance to both you and Ms Stewart's family that the Trust takes the concerns raised seriously. Should you have any further questions, please do not hesitate to contact me.

Yours sincerely,

Chief Executive