East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
26 MAY 2022

Title	**Coroner Regulation 28 Report - Prevention of Future Deaths**
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Purpose of the report

- This report provides a summary of the issues identified by the coroner in respect of a Trust service user, Mr Ottway (GO) who experienced a cardiac arrest whilst in seclusion and provides an update on the progress of the actions being taken to address the learning identified and shortcomings in areas of practice
- The Board is asked to consider whether appropriate assurance has been provided

Key messages

On 1 April 2021, Mr Ottway experienced a cardiac arrest whilst in the seclusion room on Lea Ward, Mile End Hospital. This followed 12 hours of sustained violent and aggressive behaviour. Police were called twice times and rapid tranquilisation was administered on two occasions.

The Trust's serious incident (SI) investigation identified some areas for learning, and the Trust's panel firm solicitor noted the SI was thorough and fair in their summary of inquest to NHS Resolution.

The coroner concluded that Mr Ottway died from natural causes. However, she remained concerned about the following issues in relation to his care:

- *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.*
- *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.*
- *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.*
- *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.*
- *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.*
- *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.*

- *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.*
- *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.*
- *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.*

Actions being taken to address these shortcomings in these areas of practice to improve and ensure safe practice and oversight include:

- There has been significant trust wide work around observation practice including training, testing competencies and learning lessons. There are systems in place to audit compliance and quality of the prescribed level of observations.
- CCTV and Oxehealth will be placed in all seclusion rooms to aid observations in difficult circumstances.
- Medical emergency simulations are being run regularly, across the whole organisation.
- A QI project has been introduced to ensure that the simulations are effective in Tower Hamlets.

Strategic priorities this paper supports

Improved population health outcomes	☐	
Improved experience of care	☒	Safer, more effective care
Improved staff experience	☒	Clearer expectations and process for staff to follow
Improved value	☐	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	Quality Assurance Committee

Implications

Equality Analysis	There are no identified equality issues.
Risk and Assurance	This report summarised actions taken to respond to risk-related interventions and an assurance of the processes for safe practice and oversight.
Service User/Carer/Staff	Delivery of safe reliable care is a priority for the Trust. Service users will benefit from better physical health monitoring in seclusion rooms. Greater staff confidence in how they manage situations that involve violence and aggression, in light of potential medical emergencies. Carers will have greater confidence in the safety of their loved ones.
Financial	None.
Quality	The issues highlighted are related to patient safety. Patient safety is the cornerstone of high-quality health care.

1 BACKGROUND/INTRODUCTION

1.1 On 1 April 2021, Mr Ottway experienced a cardiac arrest whilst in the seclusion room on Lea Ward.

1.2 This followed 12 hours of a sustained violent and aggressive behaviour. Police were called twice and rapid tranquilisation was administered on two occasions.

1.3 The Trust's serious incident (SI) investigation identified some areas for learning and improvement. The Trust's panel firm solicitor noted the SI was thorough and fair in their summary of inquest to NHS Resolution (NHSR).

1.4 The coroner concluded that Mr Ottway died from natural causes. However, she remained concerned about the following issues in relation to Mr Ottway's care:

- *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.*
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- *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.*

2.0 NURSING OBSERVATIONS (Point 1, 3)

2.1 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 hypostasis had not been provided as part of the Serious Incident Review and therefore did not feature in the SI review. Since receiving the Prevention of Future Deaths Notice from the coroner, this has been reviewed further by the Clinical Director of Tower Hamlets, to determine what further action is required. At present, this is not yet clear.

2.2 Since April 2021 the Trust has been implementing a plan to improve observation practice. Across the trust all staff within inpatient services have received training and undergone competency assessment, with practice being monitored through regular audit. The Trust Observation Policy has also been reviewed and updated. Electronic recording of observation is also in the process of being rolled out and implemented across services.

2.3 Additionally refresher session on effective observations for service users in seclusion took place on 19 May 2022 for Rosebank Ward, and will take place on 26 May 2022 for Millharbour Ward and 20 July 2022 for all Duty Senior Nurses. The lessons from this Serious Incident are also being shared with staff across the organisation as part of all inpatient away days.

2.4 The Trust is also currently rolling out the Oxehealth system to monitor signs of life in seclusion rooms. The installation of this system will be completed by the end of June 2022 in Tower Hamlets and there is a program of installation for all seclusion rooms in the Trust, with a completion date of September 2022. In support of this, all inpatient staff who carry out seclusion observations will receive training on the use of Oxehealth. The CCTV in the seclusion room has also been upgraded to improve visibility and has a live stream to support observations.

2.5 These enhancements to seclusion rooms will enhance the ability to observe service users whilst in seclusion. Whilst this does not replace the need for effective nursing observations (and is not intended to), they will provide a valuable adjunct to improve patient safety overall.

3.0 SECLUSION ROOM ENTRY (Point 2,6)

3.1 Safety and Management of Secluson training requires a certain number of staff be present prior to entering the seclusion room, especially if a service user has a history of violence. As part of the response to this incident, the Trust Seclusion Policy is being updated to be explicit about effective response in a medical emergency, and how the Oxehealth system can support this. This review and update of the policy will be completed by the end of August 2022.

4.0 PERSPEX PANEL VISIBILITY (Point 4)

4.1 The Perspex panel has been replaced and is now clear and this forms part of the environment checks.

5.0 EMERGENCY RESPONSE (Point 5,7,8,9)

5.1 In response to the need to provide effective response to emergency medical situations, emergency response simulations are held across the Trust, including on Tower Hamlets inpatient wards. These are in addition to the Intermediate Life Support training that staff receive as part of their mandatory training (within which compliance is monitored). These

simulations enable staff to practice the prompt response to emergency situations in order to enable an effective response when a real emergency occurs.

5.2 Intermediate Life Support Training does not include venous access or the administration of drugs such as adrenalin. This would be given in Advanced Life Support training which takes place in Acute hospitals. Staff within mental health inpatient services are trained to identify the deteriorating patient and provide cardiopulmonary resuscitation in the case of a cardiac arrest. We do not train staff on mental health inpatient units to cannulate or administer intravenous medication. This is in keeping with the national picture

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

5.4 In all 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 and has been communicated to all staff across the inpatient services. The review of the Trust seclusion policy also includes this requirement.

5.5 The Trust's junior doctors are now included in all of the emergency response simulations. In addition, 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 contained within it.

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

6.0 ACTION BEING REQUESTED

6.1 The Board is asked to consider whether appropriate assurance has been provided.