Assurance Statement from 2gether NHS Foundation Trust regarding the serious incident on 9th July 2014

As a Trust we continue to express our deepest condolences to Sharon's family.

An incident occurred on 9 July 2014, where a patient resident on our Montpellier Low Secure Unit, Wotton Lawn Hospital, Gloucester, tragically killed Sharon Wall, a highly valued Trust employee and colleague.

2gether NHS Foundation Trust welcomes the publication of this report and accepts its recommendations. As a Trust we are absolutely committed to working to ensure that the likelihood of such an event is never repeated.

Following the incident, a number of high profile comprehensive investigations took place including: a police investigation; a Serious Incident (SI) Investigation undertaken internally by 2gether NHS Foundation Trust, Investigation by the Health and Safety Executive (HSE) and an independent investigation commissioned by NHS England.

The detailed and in-depth 2gether SI Investigation, and subsequent Health & Safety Executive (HSE) investigation, concluded that the incident had not been predictable or preventable. To help strengthen and improve our services at Montpellier and other areas of the Trust our internal SI investigation identified a number of recommendations

These included:

1. Changes to the overall management of violence and aggression within the Unit.
2. Additional security arrangements, including the deployment of advanced technology using magnetic anomaly scanning for the identification of potential metallic weapons and other restricted items.
3. Development and rollout of an enhanced Search Policy and training programme within the Unit and the wider hospital.
4. Enhanced staff training regarding Personality Disorders and the management of complex patients.
5. Changes to how the Unit team were supported, including supervision and individual support arrangements, recruitment and retention.
6. Deployment of further advanced technology to enhance the management of security and the monitoring of patients internet usage

All of the recommendations from the internal report were discussed and agreed with the HSE and were fully implemented/completed during 2015. The HSE investigation which was concluded in 2016 noted the completion of those recommendations. The HSE investigation also stipulated a required range of actions and mandated improvements in risk assessment, lone working and the search policy provision which should be implemented by the Trust.

The independent investigation commissioned by NHS England was undertaken by Anne Richardson Consulting. The independent investigation was completed in March 2018. The independent investigation team were able to confirm that all of the recommendations from the internal investigation report, including those mandated by the HSE, had been met.

Since this tragic event our thoughts have focused heavily on the loss experienced by Sharon's family which has driven our intent as a Trust, that we are absolutely committed to in our work to ensure that the likelihood of such an event is never repeated.