South Tees Hospitals NHS
NHS Foundation Trust

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Web-site: www.southtees.nhs.uk

TH/RGW/mc

20 January 2014

Ms C Bailey
Assistant Coroner
Teesside Coroner Area
The Coroners Service
Middlesbrough Town Hall
Albert Road
MIDDLESBROUGH TS1 2QJ

Dear Ms Bailey

INQUEST INTO THE DEATH OF STUART AARON COLLINS

I am writing in response to your letter of 18 November sent under Regulation 28 of the Coroner's regulations 2013. I would like to assure you that this matter has been discussed at a senior level in the organisation and we have carried out a full investigation into the matters raised by yourself at the inquest. In answer to your specific points I would make the following observations:

1. **There appeared to be a degree of uncertainty as to whether Mr Collins was assessed upon his arrival at the A&E department at James Cook University Hospital ("the hospital") at approximately 00:45 or whether information previously obtained from paramedics was utilised in lieu of an assessment on arrival.**
   That A&E records demonstrate that Mr Collins was triaged on his arrival by Charge Nurse [redacted] He used an evidence based ABCD approach, assessing the patient's airway, breathing, circulation and disabilities. We can find no evidence to suggest that our observations were copied from the paramedic's documentation. If you have any to the contrary, I would be glad to receive it.

2. **It was stated that Mr Collins should have had hourly nursing observations taken during his first admission to A&E on 9.10.12 i.e. between 00:45 and his discharge at 04:30 but none was taken.**
   The trust policy G136 Recognition and Response to Acute Illness in Adult Hospitalised Patients sets out minimum standards for routine physiological monitoring. Mr Collins Early Warning Score was calculated as 2 on admission and according to trust policy this would not have triggered a more frequent level of observation than the 4 hourly plan. Mr Collins was therefore managed in accordance with current trust policy and indeed

national guidance around the Early Warning Score and frequency of observations. We do however acknowledge that a further set of observations would have been preferable prior to discharge whilst noting that throughout his stay this gentleman was uncooperative and refused all nursing care and interventions when approached by staff.

3. **Evidence was given that Mr Collins was added to the whiteboard in the A&E department but that the information regarding the frequency of his nursing observations was not. It was stated that this led to no nursing observations being taken during his first time at A&E on 9.10.12.**
The Accident and Emergency Department now has what is known as a "Patient Status at a Glance Board" which is in effect a notice board where patients requiring regular observations and specific investigations are noted, this was introduced in October 2013. At time of Mr Collins' admission the white board in the department was used to record the patient's presence but did not include their clinical management plan.

4. **Evidence was given that the nursing notes in A&E were not fully completed and were not kept up to date. There was no apparent recording about Mr Collins' epilepsy or the need for the hand sanitiser gel to be moved out of his reach.**
Mr Collins' details were entered into the A&E electronic system during the triage assessment by the charge nurse in attendance. It was noted at this point that Mr Collins had a critical patient information flag on his record which identified that he was known to the service and had a management in place. As you know, he had been a regular attender in the department (77 times in total with 63 of these in the previous 12, months). Staff were therefore naturally very familiar with his past medical history. The flag was signed by a charge nurse to document that it was acknowledged and then prompted the nurse to refer to the management plan and highlight Mr Collins' history to the attending doctor. It was in response to this information that all sanitiser gel dispensers in the near area were removed and placed at the central nurses' station.

   Please note, we accept that the nursing records are not completely contemporaneous.

5. **Evidence was given that the hand sanitiser gel was collected from the A&E department. However further evidence was given that the collected hand gels (estimated at 20 in number) were placed on the nurses station very close to Mr Collins' cubicle. There was contradictory evidence as to whether Mr Collins could have accessed the hand gel from the nurses' station.**
It is our belief that the removed hand gels were not placed close to the cubical occupied by Mr Collins. They were in fact on a desk are of the central nurses station which is the middle of the A&E Department. The design of the department ensures that all cubicles are visible from the central nurses station. This is manned by staff 24 hours a day so in order for Mr Collins to access the gel at the nurses' station he would have had to remove himself from his trolley and walk through the department to the staff at the station and others in the department. This seems unlikely without the individual having been seen.

   Whilst dispensers were removed in the vicinity of Mr Collins the organisation is of the opinion that it would be unrealistic and indeed increase risk for other patients, if dispensers were completely removed from the area, as staff are required to use them in line with Trust policy HIC 14 the Hand Hygiene Policy. Therefore a judgement of the balance of risk to both staff and patients had to be made.

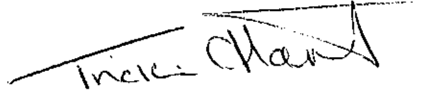
Ms C Bailey

20 January 2014

We can find no evidence to the effect that Mr Collins was able to access hand gel at the nurses station. If you have any evidence to the contrary or any evidence that this contributed to his death we would be grateful to receive it so that we can investigate further.

We very much regret that this incident occurred and have put measures in place to ensure that there will be no repetition of these events. In particular, we have ensured that all staff are made aware of the importance of contemporaneous record keeping to demonstrate actions taken and clear decision making. At the same time, we have made all staff aware of the current white board system within A&E. I can confirm that this case has been discussed at the A&E Department Team Meeting and at various other levels throughout the organisation. I would like to sincerely thank you for raising the issues that you have with us. I would like to assure you that we have taken the matter extremely seriously and are most earnest about taking whatever learning we can from this extremely unfortunate event.

Yours sincerely



Professor Tricia Hart
Chief Executive