Tameside Hospital NHS
NHS Foundation Trust

Chief Executive Office
Silver Springs
Tameside General Hospital
Ashton-Under-Lyne
OL6 9RW

Our Ref: PW/KJ

Date: 9 January 2015

Mr Pollard
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Pollard

Elsie Mallalieu (Deceased)

I write further to your letter dated 17 November 2014 enclosing a Regulation 28 Report issued at the conclusion of the inquest concerning the death of Elsie Mallalieu. I am very sorry that you found cause to issue this report and I hope to be able to address your concerns to your satisfaction in this letter.

Dealing with the five concerns raised in your Regulation 28 Report:

1. **During the course of her relatively short stay in the hospital she was moved to Ward 41 which, as agreed in evidence by senior medical staff, was an inappropriate ward for her.**

   Response
   Following detailed investigations, action has been taken to minimise the risk of inappropriate transfer occurring in the future. Training has been provided to doctors in the Orthopaedic Department to make them aware of the following:

   (a) That a patient's consultant or alternatively a senior member of the consultant's team must be involved in any decision to transfer a patient between specialties and / or ward areas and that the discussion about transfer and the decision taken must both be clearly documented in the patient's medical records.
   (b) That patients on the Trauma Unit under the care of the orthogeriatrician team should not be moved unless the patient's care needs to be escalated, for example to our High Dependency Unit.

   This training also forms part of the induction process for junior doctors working in the Orthopaedic Department.

Also, on 24 April 2014 our solicitors provided a copy of the Trust's investigation report to your office. Page 12 of that report contains the investigating panel's conclusion that it was inappropriate for Mrs Mallalieu to have been transferred from the Trauma Unit to Ward 41. The decision to transfer was not in Mrs Mallalieu's care plan and it should not have occurred.

2. **She was entirely dependent on high-flow oxygen but none of the staff on Ward 41 were trained to use this equipment.**

   Response
   Page 8 of the Trust's internal investigation report confirms the outcome of the Trust's investigations; that at the time of handover from the Trauma Unit to Ward 41 the need for high-flow oxygen therapy and the skills to use that equipment should have been discussed and resolved before any transfer was completed. The on-call physiotherapist who was familiar with the equipment for high-flow oxygen attended the ward to review Mrs Mallalieu and was available to assist the nursing staff with it.

   We have taken action to address this by communicating to all staff that where possible, staffing levels and skills must be considered prior to transfer between specialties and / or ward areas, to ensure that patients continue to receive the appropriate level of care. Additionally, a schedule of training has been put in place for the staff on Ward 41 regarding high-flow oxygen, although it is rarely used by staff on Ward 41. Training by the Trust's equipment trainer has progressed and sessions will be on the wards where all staff would be able to attend as appropriate. In the meantime, the physiotherapists are also providing staff with training on the wards when there is a patient requiring high flow oxygen. Following feedback, we know that the physiotherapists are being very supportive in this interim role.

3. **The medical and nursing notes on Ward 41 were woefully inadequate and failed to record some of the most basic care which was, or ought to have been given.**

   Response
   The Trust's internal investigation identified deficiencies in the record keeping in this case and is undertaking a review of its current training on record keeping standards. Such training will reinforce the need for clarity and completeness.

   There is also a proposal for integrated health records and for a pilot project to take place for each specialty within the Trust. A task and finish group is currently exploring this but to date ITU, Outreach and AMU began trialing integrated notes in November 2014. Integrated health records are now standard across most Trusts and should safeguard against vital information being lost as well as having a more universal and systematic approach to sharing information. Overall, it will provide a more transparent and robust approach throughout the Trust.

4. **Whilst the staffing levels on Ward 41 probably met the national guidelines, it was clear that the ward was exceptionally busy both as to numbers of patients, but also as to the complexity of their conditions. There were only two qualified staff available and they simply could not cope (an example of this was that she had her observations taken at 8.30pm approximately, and not thereafter for the**

whole of that night shift. A doctor attended her at approximately 2.30am and "guessed" her observation scores or alternatively used those of several hours earlier. Her PARS score at 8.30pm was recorded (wrongly) as 4 (it was in fact 6) and by the following morning day shift it had risen to 10.

Response

The staffing levels on Ward 41 did indeed meet the national guidelines. The ward was staffed with auxiliary staff in addition to the two qualified nursing staff. However, since Mrs Mallalieu was treated the Trust have taken further action to reduce the use of agency staff and address substantive vacancies and ensure Registered Nursing levels are maintained.

Nurse staffing levels are being monitored through multiple assurance sources including the Trust Board Hard Truths paper. Additionally, the Trust's Board is actively monitoring staff levels and the skill mix across the Trust. This involves staff levels being considered daily alongside daily staffing level reports and bed management, which involves the Deputy Director of Nursing. There is also a focus on reporting low staffing levels following which there is an escalation process involving the individual nurse in-charge, the senior nurse, the Divisional Head of Nursing and the Director of Nursing. This will also enable senior nurse intervention and support where required. Currently, this involves a Capacity Planning communication which is circulated five times per day with revised and refocused reporting tool along with four bed meetings per day with additional conference calls to support escalation planning.

Staffing is also being assessed as part of ward based accreditation and unannounced walk rounds.

With regards the failure to take observations during the night shift; this occurred because a member of the nursing staff unfortunately miscalculated the PARS score, which meant that Mrs Mallalieu did not have her observations taken as she would have done if scoring had been correct. Since Mrs Mallalieu's treatment the PARS scoring system has been replaced by a different system called NEWS and Trust staff have been trained in the use of it. A quick reference NEWS escalation and response guide has also been made available to all staff. The NEWS system is more sensitive than most other existing systems and it provides an enhanced level of surveillance and clinical review of patients with greater specificity in identifying those at risk of clinical deterioration.

In relation to the example given of a doctor who attended on Mrs Mallalieu at 2.30am and "guessed her observation scores or used them from several hours earlier" I can only sincerely apologise for the actions of this particular individual concerned in the care of Mrs Mallalieu. Please be assured that this doctor did not act in accordance with the Trust's PARS system and the Trust does not tolerate such an approach. All clinical staff are trained accordingly on PARS scoring (now NEWS scoring) and refresher training is provided as and when necessary. Any member of clinical staff who fails to correctly follow such training will be appropriately dealt with and professional requirements considered.

5. **A consultant agreed with my conclusion that this patient was "written off" and that a DNAR should not have been placed and that she could have been**

escalated to ITU / HDU where the infection which in fact led to her death, might have been treatable. Whilst on Ward 41 she was administered antibiotics for this condition but the nursing staff had failed to "turn on" the drip delivering the drug.

Response
Although, as addressed above, Mrs Mallalieu should not have been transferred to Ward 41 from the Trauma Unit it is certainly not the case that she was "written off". Nevertheless, admittedly she was a very ill patient with a poor prognosis and this was supported by the Trust's commissioned independent expert report of [redacted] Consultant Geriatrician which was sent to your offices prior to the inquest.

The opinion of [redacted] admitted in evidence at the inquest was that *"overall Mrs Mallalieu was very ill with a poor prognosis for survival. Once the decision had been made not to escalate her care to ITU for ventilation her death was inevitable. On the balance of probability my opinion is that even if she had been ventilated in ITU she still would have died in any event within a day or so."*

You will also note [redacted] opinion of Mrs Mallalieu's condition when she deteriorated on the morning of 15 August 2013 *"she received prompt and thorough appraisals from suitably experienced doctors who prescribed the correct treatment. They requested an expert opinion from an ITU consultant which was given in a timely manner. The DNAR decision was in my opinion entirely appropriate and understood by the family. The decision not to escalate to ventilation on ITU was reasonable and in accordance with responsible medical opinion."*

I do hope that I have addressed your concerns and that I have reassured you that the steps taken by the Trust will prevent the recurrence of a similar set of circumstances as those in the case of Mrs Mallalieu.

Should you have any further questions arising from the contents of this letter please do not hesitate to contact me. I am again sorry that your investigation into this death caused you such significant concern to issue a Regulation 28 Report but I hope that you are now reassured.

Yours sincerely

[redacted]

Karen James
Chief Executive