Barts Health NHS Trust
Trust Executive Offices
Ground floor, Pathology Block
The Royal London Hospital
London, E1 2ES
Telephone: 020 32460632
www.bartshealth.nhs.uk

Ms Jacqueline Devonish
Assistant Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

13 January 2016

By special delivery

Dear Ma'am,

Inquest touching the death of David Alan White

I write in response to a Regulation 28, Report to Prevent Future Deaths, dated 11 November 2015, which was made at the conclusion of the inquest into the sad death of David White. Barts Health NHS Trust takes Coronial investigations very seriously and I am sorry you have had to make Preventing Future Death recommendations and I am grateful to you for highlighting your concerns.

I note David Alan White died after suffering a fractured neck of right femur following an unwitnessed fall on the ward and your concerns relate to the lack of nursing documentation and lack of care plan review relating to his mobility.

The concerns you have raised in the Preventing Future Death report are:

1. The effect of Heparin, in causing confusion, was not in the records, and therefore not acted upon.

2. Nursing notes documented a risk of falls/mobilisation and action to be taken, but there was no supervision arrangement in place. One to one care had been in contemplation.

3. Whilst nursing notes were being kept about the risks, the records were not being reviewed and acted upon.

We have investigated the above concerns and I can confirm:

1. The members of staff have been reminded of the importance of adhering to the normal process of 'documenting allergies and adverse effects' regardless of how unique the reaction may be as in this case. This issue has also been discussed in the Renal Mortality and Morbidity meeting as a learning point for

all teams and members of staff on the importance of documenting drug-related issues and the escalation of this information to senior clinical staff.

2. The safety briefing during nursing handover is now to include a verbal handover of the care plans for patients assessed as at risk of falls to alert incoming staff members as to the risk and care plan.

   It has been emphasised to all senior nursing staff that daily auditing of all nursing and falls risk documentation must be carried out. This will ensure that call bells are within reach of patients and that all assessments and any changes in care plans are highlighted in the medical records.

   We have reviewed the escalation of our 'Specials' requests to Bank Partners so that patients can be appropriately monitored and supervised (one to one) when they are assessed as at risk of falls and/or confused. Site managers can now be contacted out of hours to ensure appropriate management of care.

3. Multidisciplinary Team meetings on Ward 9F have now been changed to earlier in the day to discuss patients and make effective action plans for patient at risk of falls. This meeting consists of medical/surgical teams, physiotherapy, Occupational Therapists and the Ward Nurse in charge and includes a medical handover to ensure communication of any deterioration overnight that could influence risk of falls, such as increased confusion.

   A practice development team has been recruited to support ward staff in adhering to ward protocols and procedures including documentation, assessment of risks and communication. We also have facilitated training from the 'Falls Lead' for the Trust to re-train nurses regarding the fall procedure and management and this took place on 29 June 2015.

I am once again grateful to you for bringing this case to my attention and I hope this letter fully answers the concerns you have raised.

Yours faithfully

J.E. Martin

Professor Joanne Martin
Medical Director
Barts Health NHS Trust