Private and Confidential

Mr C.G.Butler
Senior Coroner- Buckinghamshire
29 Windsor End
Beaconsfield
Buckinghamshire, HP9 2JJ

16th September 2016

Dear Mr Butler,

Regulation 28 Report– Stephen John Bird

I am writing in response to your Regulation 28 Report of 22 July 2016 following the Inquest of Mr Stephen John Bird.

You have asked the Shelburne Hospital ("Hospital") for a response to the matters of concern raised within the report and to detail the action/s and proposed action/s to be taken by the Hospital, along with the timetable for these actions. Please see our responses below.

Concern 1

The patient records, the documentation of consultations, clinical decisions, changes to previous assessment and discharge records were incomplete, inconsistent and/or conflicting and this was acknowledged during the inquest hearing.

It is accepted that the standard of record keeping was poor and not in accordance with the standards expected by BMI Healthcare ("BMI"). The following issues were identified:

- The consultant surgeon's documentation was poor. There were no contemporaneous records of consultations and clinical decisions made.
- Mr Bird's VTE risk assessment undertaken at pre-assessment was not updated on admission.
- The World Health Organisation safer surgery checklist was incomplete.
- Mr Bird's pain score/status was not documented on return to the ward or on discharge.
- It was documented by the physiotherapist that stairs were declined by Mr Bird but the reason for decline was not documented.
- The discharge paperwork was inaccurate.

- The discharge follow-up phone call was not undertaken.

- Abbreviations used in the physiotherapy notes created confusion.

In response to these concerns the following actions have been identified:

1. At the Hospital Medical Advisory Committee (MAC) meeting on 21 July 2016 the consultant record keeping was discussed. The committee took a serious stance on the standard of record keeping by consultants and it was agreed that there would be zero tolerance to non-compliance of GMC Good Medical Practice Guidelines on completion of medical records. Consultant medical records will be audited by the Director of Clinical Services on a monthly basis and non-compliance by any consultant may result in suspension of the consultant's BMI practicing privileges. The MAC Chair and Executive Director wrote to the consultant body of both BMI Shelburne and BMI Chiltern Hospital accordingly on 25 August 2016.

2. Documentation training for staff at BMI Shelburne and BMI Chiltern Hospitals commenced on 15 August 2016 and is on-going on a monthly basis.

3. Corporate review of the use of abbreviations by physiotherapists is to be undertaken by BMI's Group Clinical Services Director and the National Lead for Physiotherapy Services this month. In the meantime a list of abbreviations issued by The National Lead for Physiotherapy Services for outpatient documentation only is in use.

4. A monthly audit of discharge follow-up phone call documentation has been introduced and commenced on 1 August.

5. All Hospital staff to review the BMI Venous Thromboembolism (VTE) Prevention policy, which commenced 1 August. The Director of Clinical Services is collating signature sheets as evidence of compliance.

Concern 2

Evidence given regarding the investigation by the hospital into Mr Bird's death and the preparation of the draft Significant Clinical Incident investigation (SCII) Report (disclosed as part of the inquest process) identified an assumption of facts within that draft report which conflicted with documentary records and this was acknowledged during the inquest hearing. It was indicated during the hearing that the hospital places reliance upon SCII reports as part of a learning process.

The investigation report used for the investigation into Mr Bird's death and the inquest process was the BMI Signficiant Clinical Incident Investigation Report. However, the BMI Root Cause Analysis ("RCA") report should have been used. Further, the report in places differed to the documented notes in the medical records.

Please be advised that reports concerning the investigation of the death of an unexpected patient remain in draft format pending conclusion of the Inquest to ensure all issues identified at the Inquest can be addressed in the report.

In response to these concerns the initial investigation report has been reviewed and a RCA has been completed. We enclose a copy of the finalised RCA.

I would like to assure you that we have taken the matters of concern identified in your report extremely seriously. Progress with both completed and outstanding actions will be reviewed and monitored and learnings shared across the BMI Group.

I trust the responses given have addressed your concerns and may I take this opportunity to again express the Hospital's sincere condolences to Mr Bird's family.

Yours sincerely

Fraser Dawson
Executive Director