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Ms Mary Elizabeth Hassell
Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
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26 August 2016

By Special Delivery

Dear Ma'am,

Inquest touching the death of Margaret Emily Tuck

I write in response to a Regulation 28, Report to Prevent Future Deaths, dated 26 July 2016, which was made at the conclusion of the inquest into the death of Margaret Emily Tuck. 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.

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

1. Although a falls risk assessment was conducted upon Margaret Tuck's admission to hospital, when it demonstrated an increased risk of falling no falls prevention care plan was drafted.

And, whilst most of the preventative measures that would have been detailed on such a care plan were implemented in any event, Mrs Tuck was described on the risk assessment as having no walking aids. In fact, she had a zimmer frame, and it was while reaching for this zimmer frame that she fell on the acute admissions unit.

2. There was confusion about which nurse had primary responsibility for Margaret Tuck. Recourse was had to the bed diaries, but there was further discussion in court about whether the nurses had been sharing care. Such a lack of clarity seems undesirable.

3. After her fall, Mrs Tuck was seen by a junior doctor who examined her thoroughly and filled in the medical portion of the post falls checklist. However, the nursing aspect of this form was never completed.

The FY1 had wanted a neurological observation to be undertaken in addition to the protocol neurological observations of every 30 minutes, but her note was not wholly

clear, and could have been interpreted as seeking only one neurological observation in total.

In fact, no neurological observations at all were conducted on the day that Mrs Tuck fell, nor the day after.

The FY1 doctor had wanted to speak to the primary nurse before leaving the bedside, but had been unable to find her. The twin nursing failures of documentation and observation might have been avoided if such a conversation had been mandatory, and there had been a simple way of achieving this.

4. Mrs Tuck had been alert and orientated upon admission on 13 October, and remained so until the afternoon of 16 October, despite her persistently low sodium. When a haematology registrar found her to be confused however, an assumption was made that this confusion was the result of low sodium.

It may be that this doctor was unaware of the falls and as a consequence did not consider the possibility that the confusion had been caused by a bleed, but this was the time when a CT scan was indicated.

5. The consultant in charge of Mrs Tuck's care did not learn of the 15 October fall until 17 October. It seems that the junior doctors on her ward did not bring this to her attention.

Mrs Tuck's nephew, however, was gravely concerned to find his auntie unable to communicate and brought this to the attention of the consultant. The consultant asked him "What do you want me to do, scan her brain?" and he replied "I think that would be a very good idea". Hence a CT scan was conducted on the afternoon of 17 October.

6. I heard at inquest that agency nurses are unable to input into the trust reporting system (Datix). Bearing in mind that at times 50% of the ward staff are agency nurses, the matron who gave evidence suggested that agency nurses could be given a card similar to that given to locum doctors, so that they would not have to trouble their colleagues to help them make such reports.

She was unsure whether this idea was going to be taken forward.

7. The hospital investigation into the circumstances surrounding the death was conducted by a ward manager. The thinking behind having a senior nurse explore questions of nursing care is obvious. However, the report also commented on aspects of medical care that the report author freely admitted in court were outside her area of expertise. In terms of learning lessons for the future, this seems sub optimal.

Clinicians giving evidence disagreed with some of the report's conclusions, but I was not able to explore those areas with the true originator, because the views had come from a consultant who the author had consulted informally.

The report was not recorded as being co-authored, and the doctor who had been asked for his view was not an oncologist. The author thought on reflection that an oncologist would have been better placed to comment on the medical management.

We have investigated the above concerns and I can confirm:

1. The Hospital has undertaken a major piece of work to ensure vulnerable patients are identified and cared for, ensuring their risk of falling is minimised. A falls working group meets monthly, with each clinical area having to present their incidence of falls and work in progress around reduction of these incidents. On the AAU (representative of most clinical areas) all patients are assessed using the Trust falls assessment paperwork (which has been newly amalgamated into a nursing documentation admissions booklet), and any patient identified as a high risk, is then issued with a brightly coloured wrist band with the words 'HIGH RISK OF FALLS' printed on it. This signals to all staff, whether regular or agency, that this patient is at risk. All our high risk patients are now nursed within a bay that allows direct observation by nurses at the nurses' station. There are plans for a Frail Elders Unit (FEU) in the near future, and this should allow better care of these highly vulnerable individuals.

2. Since this incident the staff allocation has been revised, all patients admitted to the AAU now have a clearly identified, named nurse. Patients and their carers are made aware of this nurse on admission to the ward. All nurses on the unit, whether they are regular or agency nursing staff, will be made aware of the nurse in charge at the beginning of each shift. In April 2016 we increased the number of senior sister charge nurse posts to increase the presence of senior nursing leadership across the 24 hour period. This has led to far better leadership and care.

3. Our Nurse Educator has been instrumental in setting up and delivering a new multi-disciplinary training programme around important issues, that includes falls prevention awareness and post falls care. As part of the Band 7 role regular assessment during the shift of care planned and delivered, is undertaken. All of our medical staff, including FY1's, are invited to participate. Falls prevention and awareness is also included in the FY1 mandatory education programme. With the increased presence of Band 6 and 7 nurses on each shift all the clinical staff now have a first contact who they can handover important issues to, even when the named nurse is not on the ward. There are now four multidisciplinary board / handover meetings per 24-hours and these are focussed around patient safety and handover. This use of the named nurse and the increase in substantive fill rate, improves continuity of care and communication.

4. and 5. There was breakdown in communication between the ward doctors, the Health Care of the Elderly (HCoE) team, and the Haematology team. These issues will be dealt with in one or more of our four daily handover meetings.

6. As with all staff (medical, nursing and allied healthcare professionals), no-one needs a card of any description to log on and write a Datix. All our computers have generic log-ins that are given to all staff that need to access the computers and once logged in they can use the intranet to access the Datix system. The senior nurse on duty has been re-instructed to allow agency nurses to use their email address in the reporting system.

7. All Serious Incidents and Morbidity and Mortality issues are discussed at our monthly and quarterly unit Governance meetings. All learning points are discussed and disseminated to all members of the AAU team, including all grades of nursing and medical staff. During the investigation the author of the report sought medical advice from the Clinical Director in Neurosciences. Both AAU and HCoE teams see such cases on a near daily basis, and are expert in dealing with the acutely unwell medical patient. We regret that miscommunication led to the delay in obtaining the relevant scan and believe the measures outlined will address such communication barriers.

The hospital is adopting a process of round table discussions to investigate serious incidents. This will ensure that relevant expertise is obtained and the expert is named in the report. We regret that such expertise was not available to you first hand at the inquest and will in future ensure better representation from our clinical staff.

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

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[redacted]
Chief Medical Officer
Barts Health NHS Trust