University Hospitals of North Midlands NHS Trust

Your Ref: 10393
Our Ref: INQ/084/17
Date: 18th June 2018

Executive Suite
Trust Headquarters
Springfield
City General Site
Newcastle Road
Stoke on Trent
ST4 6QG

Tel: 01782 676612

Email: [redacted]

STRICTLY PRIVATE & CONFIDENTIAL
Mrs M Jones
Assistant Coroner
547 Hartshill Road
Stoke on Trent
ST4 6HF

Dear Mrs Jones

Kenneth William HORNE

Further to your letter dated 3 May 2018, I am pleased to provide a response to your report under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Kenneth William Horne.

Recorded Circumstances of the Death
On 23 March 2018 HM Assistant Coroner commenced an investigation into the death of Kenneth William Horne. The investigation concluded at the end of the inquest on 2 May 2018. The conclusion of the inquest was that the deceased had a history of lung cancer in 2015 which had been operated on. In December 2016 he was admitted to the Royal Stoke University Hospital, Stoke on Trent with a chest infection. He was investigated for cancer of the colon but was unfit for further tests due to his comorbidities and general frailty. He was transferred to ward 80 where infections settled. He suffered 2 falls on the ward whilst mobilising from the toilet without nursing assistance. One of the falls was on the morning of 27 January 2017 which was also his planned discharge to Leek Moorlands Hospital where he was admitted at 7.50pm. Details of his previous falls were not included on the discharge letter and there was no verbal nurse to nurse handover. His falls documentation and risk assessments were sent with him to Leek Hospital but the transfer of care form had not been updated. At 2.00am on 28 January 2017 he was found on the floor at the side of his bed. Observations indicated a deteriorating condition and he was re-admitted to the Royal Stoke Hospital. A CT scan found a very large haematoma of the left thoracic wall and possible infection. His nutritional intake remained poor. He was not suitable for intervention and was treated as palliative. He was transferred to Bradwell Hall Nursing Home, Newcastle under Lyme on 22 February 2017 where he died on the 24 February 2017.

The cause of death was 1a: sepsis, 1b bronchopneumonia, 1c: chest wall injury, 2: old age.

Concerns
During the course of the inquest you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows:

1. The deceased has 2 falls whilst at the Royal Stoke University Hospital, one on the morning of his transfer to Leek Moorlands Hospital. The falls were not included in the discharge letter.

2. There was no nurse to nurse discharge calls between the hospitals.

3. The Transfer of Care form was not up to date. If these matters had been properly dealt with Leek Moorlands Hospital might not have accepted the transfer. He had a fall with serious injury approximately 6 hours after admission to Leek Moorlands Hospital.

4. As a side issue and a matter of concern, communication with the relatives appeared to be poor. No datix form was competed for the second fall in the Royal Stoke University Hospital until December.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Action Taken
For ease of reference, your concerns will be addressed in turn.

1. All Clinical Leads to instruct Junior Doctors and Nurse Practitioners that when summarising discharge letters, any significant event such as patient falls while in hospital is reflected on their discharge summary.

2. Ward staff to ensure that alongside the paper version of handover between UHNM and other hospitals, a verbal handover happens as part of a trusted assessment.

3. The Transfer of Care Form has now been revamped and a more comprehensive and holistic Patient Profile documentation is in place. This is a more detailed handover and requires other members of the multi-disciplinary team to contribute in its completion.

4. This incident was already shared widely across the General Medicine Department and Medical division. A Memo has been circulated divisionally to reiterate the importance of accurate and timely datix reporting.

In additional to this, the Corporate Governance Team are in the process of co-ordinating an audit of discharge summaries with our external auditors. It is hoped that this will take place within the 2018/19 financial year and any findings will be addressed by the Corporate Governance Team.

I sincerely hope that this report provides you with assurance that the Trust has taken the matters arising from the inquest touching upon the death of Mr Horne seriously. The Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these matters on this occasion.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

PAULA CLARK
CHIEF EXECUTIVE