Royal Free London
NHS Foundation Trust

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11th October 2018

HM Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Ms Hassell,

Response to Regulation 28 Prevention of Future Deaths Report – Dr Flora Baber

I have set out within this letter the Trust's responses to the Matters of Concern that you have brought to our attention in your Regulation 28 Prevention of Future Deaths Report dated 13 August 2018. I have been assisted in compiling the Trust's responses by a number of colleagues, including:

- [redacted], Quality Governance Manager, Urgent Care.
- [redacted]tin, Ward Manager, 8 West
- [redacted], Divisional Nurse Director, Medicine and Urgent Care;
- [redacted] Principal Pharmacist, Clinical Governance;
- [redacted] Adult Safeguarding Lead;
- [redacted] Group Head of Patient Systems;
- [redacted] Head of Quality Governance, Royal Free Hospital;

I have set out below each of the matters of Concern, followed by the Trust's responses.

1. **Whilst record keeping showed Dr Baber as having been given appropriate food and drink whilst on the ward in hospital, I heard that sometimes her nearest fluid was out of her reach on a bedside table too far from the bed. Also, she did not always receive appropriately pureed food or the assistance that she needed to eat.**

   Following the Inquest, we wrote to the family to seek further information from them regarding all of the issues that they raised during the Inquest and particularly the Matters of Concern that you have raised. The issues did not appear to have been raised by the family contemporaneously and unfortunately we have not yet received a response from the family to our request for further information so we have been unable to investigate any specific incidents as we would ordinarily wish to do and therefore the responses to the individual concerns are more generalised than we would ordinarily look to provide.

   The patient was cared for throughout her stay in 8 West in what is known as a "high bay", meaning that staff were present in the bay at all times to supervise the patients. This bay is also visible from the main nursing station on ward 8 West.

Water is normally kept on the patients' bedside tables and individual jugs are kept topped up throughout the day by domestic staff. However, due to the patient's subdural bleed, she was laid at a 30 degree angle throughout her final admission. Gold standard treatment and research concludes that the only position that has consistently shown to be acceptable is a head elevation of 30 degrees in patients following a brain injury. It would be expected that this would be an awkward position for any patient to be able to drink in, but the need to protect her safety in terms of the bleed was considered to be paramount. If the patient was attempting to obtain a drink and could not manage to reach it, it is expected that this would be seen and rectified by the staff member supervising the ward. There is evidence within the patient's notes of hourly rounding being done which means that Nursing Assistants specifically attended to the patient every hour to check that she was comfortable. Part of the rounding protocol is to offer patients a drink each time they are visited by the Nursing Assistant.

In addition, the Ward Manager conducts ward rounds three times per day. During these he visits all areas, starting with the high bays. As part of his checks he ensures that patients' tables are within reach when appropriate, and that they have glasses of water on them.

The patient was given a pureed diet from 13 February 2018 when it was recommended by the Speech and Language therapist following their assessment. Up until this point, the patient had been on a soft food diet and as already stated in your PFD Report, the food and fluid intake charts indicate that the patient was eating this. A soft diet consists of food such as mash, soup, custard, sauce, etc. The patient was also prescribed and administered Ensure, a nutrition supplement, from 31 January 2018. When patients are prescribed specific diets, this is included on the SBAR (daily handover sheet) so that all staff are aware on a daily basis.

This food is prepared by the kitchens and sent up to the wards. When it arrives on the ward, either a nurse or a HCA checks the food. If it was not deemed to be appropriate, it would be sent back to the kitchen and a replacement requested. This patient was on a "red tray", meaning that this flagged as a reminder to all staff that she needed assistance with eating. Either a nurse or a healthcare assistant (HCA) would bring the food to the patient and they were then responsible for staying with her to help her to eat, unless a family member was there who wanted to do it instead. Sometimes meals needed to be staggered depending on the number of patients who needed assistance at any one time.

We would be very concerned if any of our patients were not able to access their food and drink, as has been suggested in this case. As you have observed, the patient's fluid balance chart shows that she was given adequate hydration. Her blood results do not indicate any dehydration, apart from one slightly raised sodium level on 2 February 2018.

In response to your concerns, all issues raised by this case have been discussed with staff on Ward 8 West at the staff morning meetings, specifically on Tuesday 14 August 2018, the day after the Inquest, but also periodically since then. They have been reminded to ensure that patients' tables are within reach where safe to do so, and to pay particular attention to hydration needs and call bells.

Please note that the Trust's Head of Patient Experience arranges annual "place visits" in which patient representatives visit wards to observe and audit various practices. Part of this involves looking at whether patients have water and if their hospital tables are prepared ready for food to be delivered. If a patient is on a red

tray, they follow the tray from arrival on the ward until the patient is eating to ensure that appropriate assistance is given. The last round of place visits were conducted in March 2018 and no concerns were raised.

In order to assure ourselves further, two independent unannounced spot checks within the next month will be undertaken to evaluate whether patients are being given appropriate food and the necessary assistance to eat. We will also assess that fluids are in reach where appropriate and whether assistance is given if required.

Furthermore the clinical practice educator will include nutrition, safe swallow, continence care, and assistance with toileting in the HCA study days, which will be a rolling programme of education. She will also discuss this case at the study days as an opportunity to raise awareness of the patient experience. Finally, our hospital quality governance manager will present the learning from this case at the next Health Services for Elderly People specialty governance meeting.

2. **There was a delay in referring Dr Baber to the Speech and Language Team and in treating her oral thrush. Most significantly, I heard evidence that it was only when family members pointed out a problem such as pain on swallowing, that staff acted to deal with this.**

The patient was admitted to the Royal Free Hospital on 25.01.2018. The HSEP SpR responsible for the patient recalls that the patient's daughter raised a concern about poor oral intake on 30.01.2018. The patient's intake chart showed that she had eaten three quarters of her porridge, as well as all of her soup and custard so far that day, so the medical team did not feel that there was any evidence of painful swallowing at that point (which may have been an indication of the possibility of thrush).

There are daily multi-disciplinary board rounds on the ward. These are attended by the medical team, nursing staff, physiotherapists, occupational therapists, social services and dietician (on Mondays and Thursdays), psychologist (when required), and, particularly, speech and language therapists (SALT) (daily Monday to Friday). All patients on the ward are discussed at every board round, the results of which are documented in the medical notes so that all staff involved in the patient's care have an opportunity to raise any concerns, including any that may have been communicated by the family. It is expected that if staff had any concerns about the patient's swallowing ability at any point during her admission this would have been discussed with the multi-disciplinary team and action taken accordingly.

There is an entry from a member of the nursing staff on Saturday 03 February 2018 to say that the patient's daughter felt that the patient had trouble swallowing, which had been passed onto the Nurse in Charge and that the patient would be reviewed by the Speech & Language team (SALT). A further entry was made by nursing staff on Sunday 04 February 2018 in which they note that the patient appeared to have pain when swallowing and so they had escalated their concerns to the doctor.

The patient was seen by a doctor on Sunday 4 February but the focus appears to have been on possible discharge planning. There is no reference to swallowing issues in this entry.

However, the Nystatin to treat oral thrush was prescribed on Monday 05.02.2018 this would indicate a two day delay. However, we are aware that the family believe that the delay was longer (5 days) and [redacted] has already apologised to the patient's family about this.

The SpR Doctor who prescribed the Nystatin recalls the patient's oral thrush being mild at that time, which was communicated to a Camden Social Services safeguarding investigation meeting held on 15 June 2018. The outcome of that investigation was that Camden Social Services felt that no further action was required.

However, [redacted] has agreed to share the learning regarding thrush recognition and treatment with all medical staff on the ward.

There is a further entry on Monday 5 February 2018 in which nursing staff have noted that although the patient did not have any complaint of pain in her mouth on that day, she was given mouth care and encouraged to increase her oral intake, following SALT guidance. Although there is no documentation in the patient's notes from SALT at this time, this entry would suggest that the patient was at least discussed with them.

When the patient was noted to be coughing when given fluids on Monday 12 February 2018, the patient was appropriately referred to SALT. Staff were concerned about the risk of aspiration. SALT came to review the patient the following day (13.02.18) and noted that assessment was limited due to the patient's drowsiness and lack of capacity. They felt that she was a high risk of aspiration and recommended that she should only be given teaspoons of water and only 2 – 3 teaspoons of puree at a time. They also advised that consideration should be given to making the patient nil by mouth if concerns continued.

In conclusion the Trust apologises for any delay in initiating treatment for oral thrush, but we cannot find any evidence that there was a delay in referring the patient to SALT. As mentioned previously, all issues raised by this case have been discussed with staff on Ward 8 West at the staff morning meetings, specifically on Tuesday 14 August 2018, the day after the Inquest, but also periodically since then.

As previously mentioned, in order to assure ourselves further the clinical practice educator will include nutrition, safe swallow, continence care, and assistance with toileting in the HCA study days, which will be a rolling programme of education. She will also discuss this case at the study days as an opportunity to raise awareness of the patient experience. Finally, our hospital quality governance manager will present the learning from this case at the next Health Services for Elderly People specialty governance meeting.

3. Family members told me that at one point, they found the member of staff allocated to Dr Baber's bay sitting in a chair apparently asleep.

There is no record of the patient's family reporting this at the time. Such an allegation causes us great concern. If a situation like this were to occur, this would be completely unacceptable and contrary to Trust values and professional standards. The Ward Manager recalls the family stating during the inquest that this incident happened on a Saturday at about lunchtime. As stated above, a letter was sent to the family after the inquest to ask them to provide further details of the alleged incident but we have not yet received a response so again, we are only able to comment upon this in general terms.

8 West's Ward Manager has reviewed all the staff rotas for the Saturdays during this patient's admission and has spoken to all staff on shift. They all deny being asleep or being aware of a colleague sleeping.

Some patients in the same bay would have had capacity. There were no reports, or concerns raised, from them, their visitors, or other staff members about a staff member sleeping at any time. On a Saturday lunchtime there would be domestic staff, visitors, doctors, and nurses in and out of the bay regularly. Ward 8 West does not have any visiting restrictions so visitors can attend the ward at any time. They report that typically the weekends are very busy with visitors, especially around the lunchtime period. The Nurse in Charge also conducts regular walk rounds on every shift. Furthermore, as previously mentioned the enhanced bay in which the patient was situated is immediately in front of the nursing station and highly visible.

A search has been conducted on the Trust's Datix system which has shown that there have been no other incidents reported of staff members sleeping on duty on Ward 8 West at any time.

Staff shifts are normally organised so that nurses and healthcare assistants work for two to three days in a row and then have two days off. Staff rest breaks are organised and published on a board at the beginning of each shift. There is not a culture on the ward of staff missing breaks. As mentioned above, the Ward Manager has checked the staff rotas for this time period and has not seen any evidence of staff working excessive hours to suggest that they may have been particularly tired at this time.

Staff who supervise bays are doing this duty for 10hrs and 45minutes per shift. They are provided with a chair within the bay as it is recognised that this is a long time to be standing. However it is expected that they will not have prolonged opportunities to sit during these shifts as the patients in a high bay are high acuity and need a lot of interaction from staff. Nevertheless staff have been reminded that when supervising bays they should be interacting with patients where appropriate, rather than sitting for long periods of time.

All Healthcare Assistants (HCAs) and most of the senior nurses on Ward 8 West have undertaken CAPER training. HCAs generally provide the enhanced supervision for patients that need it. CAPER training includes specific guidance for interacting with patients, particularly those with dementia.

I would like to assure you that the Divisional Management Team conduct regular leadership rounds to clinical areas, which are carried out at least monthly. Some of these are unannounced. The Executive Team also plan to start walk rounds in the near future and these form part of a pre-existing overarching quality governance action plan within the hospital.

4. **Dr Baber was noted in the medical records as being doubly incontinent. However, family members told me that she was not incontinent. Rather, when she asked for assistance to go to the toilet or to use a bedpan (she had poor mobility), a healthcare assistant told her that staff were busy, she was wearing an incontinence pad, and she should use that instead.**

Ward 8 West staff report that the patient was generally doubly incontinent throughout her stay, although they report that she had moments of lucidity when she sometimes asked to use the toilet.

This allegation was not raised by the family members during the patient's admission as far as we are aware, and no further information has been provided since, as indicated above, so that any staff member involved could potentially be identified.

The Ward Manager has spoken to all staff on the ward, none of whom recall this happening.

However, if this did happen to any patient it is completely unacceptable, as the Trust strives to maintain patients' dignity at all times and it would certainly be more dignified to offer patients the opportunity to use a bedpan, rather than incontinence pads, if requested.

As the patient had been admitted with a subdural bleed, along with confusion, delirium, agitation, and visual hallucinations, it was not considered safe to encourage her to stand. The patient was assessed as being at a very high risk of falls. She was nursed in bed throughout her admission and was normally very confused. It was not felt that it would have been appropriate to assist her to a toilet, both for her own safety and for staff in terms of manual handling. However, a bed pan could have been an option. Due to the patient's confusion, it was not felt to be appropriate to rely on her being able to call for staff when she needed the toilet, and there are no records of her regularly asking for a bedpan, so it was considered most appropriate to give her incontinence pads.

All the concerns raised have formed part of a Safeguarding Conference where this allegation was discussed. The ward manager was questioned by Camden Local Authority on the possibility of this occurring and asked to evidence what processes were in place and what actions were now in hand to ensure that all measures are taken to assist patients to maintain their dignity and afford the opportunity to not use incontinence pads where possible.

All HCAs on Ward 8 West are working towards completion of a care certificate, which includes continence care.

As previously mentioned, all staff on Ward 8 West have been reminded on Tuesday 14 August 2018 and on other dates since then, that even if patients are incontinent, they should be assisted to use the commode or a toilet if they request, and if it is safe to do so. Further assurance will be sought via actions 2, 3 and 5 on the attached action plan.

5. **Dr Baber had sensitivity to opioids, such that her family noted a direct correlation between episodes of sickness and vomiting, and the administration of opioid medication. This had been recognised and recorded during earlier admissions to the Royal Free, and family had discussed with staff at the care home. However, it was not recorded as an alert on her hospital noted. At the very end of Dr Baber's life, the benefit of pain relief was thought to outweigh the side effects of opiates, but before then her sensitivity was simply not recognised. This caused her discomfort and distress, and in another case could have fatal consequences.**

It is noted that the family reported that the patient had sensitivity to opioids and preferred not to take them as she did not like the side effects. Although not strictly an allergy, this sensitivity (opiates and Cephalexin) was noted on the patient's discharge summary as such on 09 January 2018 which was sent to the patient's GP. An earlier sensitivity to Fentanyl had been notes on her discharge summary of 2016. It is understood that the GP surgery have confirmed receipt of these documents. It is regrettable that there is no robust system in place to ensure that allergy/sensitives are recorded and shared at all times. This was reported as an incident on the Trust datix system prior to the Inquest, following concerns raised by the patient's family.

Discharge summaries/ TTAs are generated on Freenet (the local Trust intranet). The TTA form provides the discharge summary and the list of medications that the patient is being discharged with.

On admission via the Emergency Department, doctors use the RFH electronic system Power Chart on Cerner, to input patient information. They currently do not record allergies on this system. However this system has the ability to record blood results and these are then automatically pulled onto the discharge summary on Freenet.

Currently, allergies and sensitivities are documented manually on the Freenet TTA form and on drug charts by doctors. They can also be amended/added by Pharmacists. Currently, allergy and sensitivity information must be manually updated each time a patient is discharged.

Learning from this incident has already been shared with Pharmacy staff as well as at junior doctor prescribing teaching sessions to remind them all that allergies and sensitivities must be recorded and checked on each admission and discharge. The action to mitigate recurrence is to ensure that all staff are reminded about the need to manually record allergies/sensitives on the Freenet TTA form and drug charts

As a short term solution pharmacy are exploring the option with IT/Cerner to assess the best possible way to record allergies and transfer them from the point of admission (recording of allergy status on Cerner) to the automated pull of this data to the Freenet TTA. We would like to continue the current option of manual amendment of the allergy status on the Freenet TTA (as this can change through the patient's stay in the hospital). We hope that Doctors, nurses, and pharmacists will be allowed the option to amend the allergy status in Freenet and Power chart on Cerner. There are a number of separate sets of programming codes for different templates required to implement these changes so this will take some time to embed, but the IT department have begun working on this. They are also exploring the feasibility of backdating allergy information for patients who have already been seen within the hospital.

In the long term, once EPR/ EPMA (electronic prescribing system) is introduced in the trust this will automatically populate the TTA/discharge summary with the allergy status of the patient from the electronic prescription. It is expected that this will go live at Barnet and Chase Farm by the end of this year, and will be rolled out across the Royal Free site in 2019. There will be prompts on this system to alert staff when an allergy has not been recorded, and it will be more easily auditable than the current system.

ADDITIONAL INFORMATION

As you are aware, on arrival at the Royal Free Hospital on the 25th of January 2018 a Butrans patch was found on the patient's skin. The staff in Compton Lodge agreed to investigate how this happened and a Safeguarding Alert was completed externally in the community by the home. This was confirmed by the hospital staff on the ward. The hospital was aware that a social worker was allocated to investigate this but they did not visit the ward while the patient was a resident.

We then became aware that the patient's daughter had raised safeguarding concerns against the Trust by email from Camden Social Services after the patient's death. Her email alleged poor standards of care, inadequate nutrition and the development of oral thrush; as a result, this patient's case was brought to the RFH Serious

Incident Review Panel for discussion. This presentation to the panel took place on 27 March 2018. The panel accepted that a Safeguarding conference of the care was required with a meeting planned to give evidence to the in-house Camden social work team and they asked that a "Learning from deaths" review be carried out.

The safeguarding conference was held on the 15th of June in the Camden Social Work Office in South House, Royal Free Hospital. Further evidence from the patient's notes was requested and following this, the case was closed by Camden against the hospital with no further action required.

The "Learning from Deaths" review was carried out by one of our Royal Free Hospital Palliative Care Consultants, who was independent of the team that were treating this patient. This Consultant reviewed all of the patient's notes and was unable to identify any issues of concern other than that he thought due to the obvious decline in the patient's health, consideration of palliative care should have been made sooner. He said that there was good documentation of care and observations, etc. He noted that there was evidence of pressure area and falls risk assessments. He noted that there were thorough capacity assessments done, with the involvement of the multi-disciplinary team. Furthermore, he has noted that the patient was given "all treatment to improve her condition" but he felt that further interventions, such as the insertion of the NG tube, could have been avoided if her deterioration had been accepted as a sign that switching the emphasis of care to symptom control and comfort measures was appropriate.

Following the inquest and the further concerns raised by the family of the care given to Dr Baber in the hospital, another Safeguarding conference was held with leads from Camden Social Services on the 18/09/2018, attended by the Adult Safeguarding Lead for the Trust and the Camden CCG Safeguarding Lead. The outcome from this meeting was that due to the added concerns raised, which had not been shared previously, further investigation was necessary. As the hospital was completing this response to your Prevention of Deaths Report, with all the concerns raised within it, Camden will accept this response in lieu of a Section 42 Care Act (2014) report. It was also agreed that we would partake in an 'After Action Review' so that Camden Social Services could confirm that all actions promised within this report were being completed.

Furthermore, as indicated above, the Clinical Practice Educator (CPE) on Ward 8 West has introduced a HCA study day, specifically focusing on elderly care. This is a rolling programme that currently includes input from safeguarding leads; mouth care; managing patients with dementia; how to raise concerns on Datix; and, the importance of thorough documentation. There is also a weekly rolling teaching session for all staff on Ward 8 West which focuses on different aspects of care each month.

We have set out below an Action Plan which summarises all of the actions that we are taking, as explained above, in response to your concerns.

If you require any further information please do not hesitate to contact me.

Thank you for bringing these matters to the Trust's attention and providing us with an opportunity to further review and improve our processes. The Trust is continuously seeking to improve the quality and safety of the care that it provides to its patients and your Preventing Future Deaths Report has been a helpful contribution to this ongoing and extremely important process.

Yours sincerely,

Dr Robin Woolfson
Medical Director
Royal Free Hospital