NHS
Brighton and Sussex
University Hospitals
NHS Trust

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[redacted]

Our Ref: gf/mf

Miss Veronica Hamilton Deeley
HM Senior Coroner Brighton and Hove
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

30 January 2019

Dear Miss Hamilton Deeley

Mrs Kalma (Kamla) Ram-Henman deceased

I am writing in response to the Regulation 28 Report which was issued following the inquest for Mrs Ram-Henman. I am grateful to you for having extended the deadline for response, in order that we could complete discussions concerning the Action Plan, as part of the Serious Incident (SI) investigation process. I attach a copy of the SI report for information, a copy of which will be sent to Mr Ram-Henman.

I would first like to express my condolences to Mr Ram-Henman and his family and friends for their very sad loss. Mrs Ram-Henman's death was a tragic event which has deeply affected all the staff involved. I am very sorry that there were inadequacies in Mrs Ram-Henman's care which compromised her ability to withstand a perforated gastric ulcer. I know that these events were shocking and distressing for Mr Ram-Henman and his family.

Following the inquest, discussions took place in team meetings for the clinical specialities involved, involving medical and nursing staff, to ensure that staff awareness of the learning issues took place as soon as possible. The inquest findings were reviewed at the Trust's Serious Incident Review Meeting, chaired by [redacted] Deputy Medical Director: Safety and Quality, and this concluded that an SI investigation should be undertaken.
In addition, a General Medicine Morbidity and Mortality Meeting has taken place, also attended by senior clinical staff from the Emergency Department (ED), to review the issues arising from Mrs Ram-Henman's care.

The attached SI report contains the Action Plan with timescales for implementation of the measures agreed.

As you will see, we have implemented a new SBAR telephone handover form (copy attached for reference) as part of the revision of the Emergency Department Safety Booklet. The form includes prompts for staff on drains and lines present, and medication issues. In the longer term, the implementation of an Electronic Prescribing System will ensure that the problems that

occurred with administration of Mrs Ram-Henman's fluids and potassium will not happen again and we estimate that the new system will be in place in approximately 18 months.

The SI investigation also showed that it has been habitual for some staff to use the "once-only" section of the drug prescription chart, when prescribing fluid/drug infusions. This section was designed to be used by ED clinicians who may need to prescribe antibiotics for patients with a suspected chest infection or who need pain relief, who are then discharged from ED. It is not appropriate to use this section for IV infusions and a Trust Safety Alert has been issued, instructing all staff not to use this section of the drug chart for infusions and that any such prescription should be completed in the normal section of the drug chart. A prompt will also be added to the front of the drug chart, reminding staff of this requirement. During review of Mrs Ram-Henman's care, it was also noted that at the time of her admission to the ward a member of the pharmacy team documented their review of previous drug history but there was no documentation concerning review of ongoing drugs prescribed. The relevant Lead Pharmacist will discuss this with the member of staff concerned and with the wider team to emphasise the importance of documenting such reviews in the patient records.

Finally, [redacted], Consultant in Acute Medicine and Clinical Lead for Ambulatory Care, has implemented a new system whereby an Acute Medicine Consultant will cover telephone calls whilst another Acute Medicine Consultant sees patients when requested. This will ensure that the Consultant seeing patients is released from answering calls and will allow more time for review and follow up of clinical plans.

I hope this letter is helpful in addressing the concerns you raised but if you need any further information please do not hesitate to contact me.

I would be grateful if you could pass on my apologies to [redacted] and his family for those aspects of Mrs Ram-Henman's care which fell below the standard which we expect and for all the distress this has caused.

Yours sincerely

Dr George Findlay
Chief Medical Officer and Deputy Chief Executive

cc. Serious Incident investigation report
Telephone handover form