Barts Health
NHS Trust

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PRIVATE & CONFIDENTIAL

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

Dear Coroner Hassell

RE: Regulation 28: Prevention of Future Deaths Report – Dawn Patricia Gill

Thank you for conveying your concerns to me by way of the above report. Barts Health NHS Trust had learned lessons following this case, and is confident that the changes planned and implemented will minimise the risk of recurrence. In response to the specific concerns raised:

Ms Gill was long term drug user and, based on her history, was likely to take illicit drugs whether she was in or out of hospital. However, while she was in hospital, no nursing care plan was made to take this into account, for example by acknowledging the higher risk that it brought. One nursing sister was not even aware that staff suspected Ms Gill of going off the ward to take drugs.

During her stay in hospital the wider nursing team and medical staff were aware of the suspicion of Ms Gill taking illicit drugs. She had been spoken to by the consultant and charge nurse and the senior nurse to advise this was not acceptable. However the nursing care plan could and should have been more explicit about this, and if it had been nursing staff would have been more aware of her behaviour and the attendant risks. All nursing teams in the hospital are being reminded of the importance of documenting the use of suspected use of illicit drugs in care plans, and of ensuring this information is part of the nursing handover.

Ms Gill was prescribed methadone in hospital and died of a methadone overdose, but her drug chart was not available at inquest and appears to have been lost.

After the coroners court we examined the CD drug register which showed that the prescribed does of methadone had been administered. The drug charts remain missing.

If the drug chart was lost during her life, then that has implications for her care. If it was lost after her death, then that would not have affected care but, however innocent the true explanation, it leaves the trust open to an accusation of trying to cover up evidence.
Whenever it was lost its absence is disappointing---Ms Gill had been found in her room surrounded by drug paraphernalia so it would have been evident to staff at the outset that drug toxicity was the cause of death.

The Trust agrees that the inability to locate the drug chart after her death and in preparation for the inquest was a serious failure, and apologises for this. We have since examined the controlled drugs register, which has confirmed that the prescribed doses of methadone in this case had been administered. The Trust accepts that the circumstances of this death made it even more important than usual that the prescribing chart was available after her death, and apologises for this failure.
The Trust is moving in 2019-20 to electronic prescribing. This will eliminate the need for paper based drug charts, and the attendant risk of them being mislaid or lost. We were aware of her drug habit but we did not see her before her death so would have not have had chance to make any diagnosis or therefore suspected a drug overdose going forward all such patients we will suspect a potential for taking non prescribed drugs and treat accordingly but do not have the powers to stop such patients leaving the ward of their own free will.

Ms Gill's room was described as having been searched on numerous occasions overnight, by more than one person, the first time approximately half an hour after she had last been seen, yet her presence under clothing on the floor was not detected until 10am the following day.

I heard nursing evidence that Ms Gill could not possibly have been in her room at the time of searching, but with the benefit of the CCTV it is now evident that she was.

The fundamental problem was that the side room occupied by Ms Gill was crowded and too full of her own possessions, making it difficult for nursing staff to do their job. While the intention was well meaning, the tolerance of Ms Gill's behaviour with respect to this matter was not in her best interests. All nursing staff have been reminded, through an anonymised vignette of this case, of the need to ensure rooms are kept tidy and organised.
Clearly the checks of the room made by nursing staff during the night in question were not adequate in that they did not detect Ms Gill's presence. The staff involved did not suspect Ms

Gill was in her room and they have had feedback about the danger of making this assumption. The root cause of the problem though was that the room was not in an acceptable state and this obstructed the nursing team from performing an adequate visual inspection.

Ms Gill was thought to have left the ward for a cigarette some time before 12.30am, though she was not actually seen leaving. She was wearing her night things. When her absence was discovered, hospital security personnel were not alerted. They could have viewed the CCTV. If they had done so, they would have realised she had never left the ward. Hopefully, this would have prompted a redoubling of search effort of the ward.

There was confusion about the circumstances when the missing person policy should be followed. I was told that the policy is not clear. The responsible nurse said it was in the back of her mind to contact security and she did not know why she had not. The sister in charge said that she would not contact security for the first two hours. The director of nursing said the contact should be immediate. The clinical site manager and the responsible nurse disagreed about the nature of the conversation between them regarding contacting security. Neither of them had made a note.

Ms Gill had been judged by the clinical team to have capacity to decide for herself whether she should leave the hospital or not under her own volition. The Barts Health Missing Person / Absconding Patient Policy is clear that this would not classify her absence as a “missing patient” but as a “self-absenting patient”. By this definition she was thought to have been a patient who had capacity, was not subject to legal detention, and who had left the hospital through her own choice, without clinical approval, with the intention of returning. In such circumstances the Trust policy states the Security team should not be called. However the policy recommends that if there is concern that the person may be missing “on Trust premises” then the Security team should be called. The problem here was that the staff did not suspect Ms Gill was on Trust premises, and they should have considered this. Our nursing teams have been reminded of the risks of making such assumptions as part of the learning from this case.

Yours sincerely

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Chief Medical Officer
Barts Health NHS Trust

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CC:

[redacted], Medical Director, Royal London Hospital
Legal Team, Barts Health NHS Trust