NHS
Barts Health
NHS Trust

15th April 2019

PRIVATE & CONFIDENTIAL

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Ms Nadia Persaud
HM Senior Coroner
Walthamstow Coroners Court
Queens Road
Walthamstow
London
E17 8QP

By Special Delivery

Dear Ma'am,

Re: Inquest touching the death of Brenda Kathleen Gowan

I write in response to a Regulation 28, Report to Prevent Future Deaths, dated 25th February 2019, which was made at the conclusion of the inquest into the death of Brenda Kathleen Gowan. 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.

Brenda Gowan was admitted to the Royal London Hospital following a stroke on 1st December 2017, and was transferred to Whipps Cross Hospital on 5th December. She was known to be at high risk of falls and was discharged with a care package on 18th December 2017. Mrs Gowan fell and sustained a catastrophic head injury causing her death on 23rd December.

I note Brenda Gowan died from a catastrophic head injury due to a fall at home in the early hours of 23rd December 2017. You have raised a number of concerns relating to the discharge planning process received by Mrs Gowan and her family.

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

1. Brenda was discharged from home, less than 3 weeks after a moderately severe stroke, for a "trial period". She required 24 hour supervision, but only 4 hours of social care was provided. Her family were expected to provide 20 hours of care. Her family did not consider that adequate steps had been taken to ensure that systems were in place to allow Brenda's safe return home. The family were concerned about the amount of care support in place; the equipment required and the access to community services. There was no evidence that the family's views were taken into account by the discharging team.

2. Brenda was at risk of falling at night. There is no evidence that the risk was fully assessed on discharge from the hospital and no evidence of the family being provided with advice on how to manage the risk.

3. The discharge plan was based upon Brenda being settled at night time. When the family reported that this had changed and that Brenda was “up a lot” – the care plan for Brenda should have been reconsidered.

4. There were no community support arrangements in place for the family to access, as the OT services had no contractual arrangement in place with Brenda’s registered GP.

5. The equipment required for managing the risk of falls had not been provided prior to Brenda’s fall (5 days after discharge from hospital).

6. There was no comprehensive plan in place to address key aspects such as how care would be provided during the trial period. Such a plan could include the risks identified and how they were to be managed; the equipment required and ensuring that it was provided, installed and those providing the care trained in its use and ensuring that the community support is available. Such a plan should be discussed with the community carers (family in this case) and key aspects agreed with them before discharge

We have investigated the above concerns and I can confirm:

Following the concerns raised by the family in regards to feeling that they lacked choice and support during the discharge process, there has been a review of the communication and documentation following a Family Care Planning Meeting ensuring that there is signed understanding of the expectations and actions by all parties. This reformatted documentation will support accountability and be uploaded to the electronic notes system and a copy given to the patient and family. This will include all of the MDT (multidisciplinary team) looking after the said patient.

The Care Planning documentation will address the risks identified and how they are to be managed; the equipment required and whether it will be installed prior to discharge; the plan for any required training and detail of the community support available.
Where equipment is required as essential for discharge this provision will be in place prior to discharge and checked as part of the discharge checklist. The completion of the Discharge Checklist will be monitored by the Ward Manager to ensure correct completion. Where needs change these will be re-assessed by a senior professional and where risks are identified this could include urgent re-admission to the stroke pathway.

Mrs Gowan’s family were ill-prepared for the task of providing the care for their mother outside of the time periods during which carers were supplied by Adult Social Care. The transition from hospital to home is recognized as a high risk period after such a life-changing event such as a stroke. Peace Ward will take steps to ensure that informal carers are given the opportunity to prepare. Firstly by ensuring the written documentation of care planning meetings are provided as described above. Secondly experiential training will be offered including the opportunity of a hospital stay with the patient to provide the care which will be required at home. This would include an overnight stay.

The current provision of carer guidelines has been reviewed and will be included in the discharge information provided to the patient and family on leaving hospital as part of the discharge checklist. This will ensure that contact details in regards to onward referral and joint health and social care planning are accessible.

We are however aware that the provision of responsive community care was not readily available for Mrs Gowan due to the limitations in stroke Early Supportive Discharge (ESD) provision at the time for Redbridge residents. Though a service does now exist, in order to ensure the safety of a patient requiring 24 hour supervision, Barts Health would not allow the discharge of such a patient without the acceptance from such a team and clear identification of risk mitigation.

All of these changes will be reviewed within the monthly Stroke governance meeting for audit and re-evaluation.

We can provide you with a copy of the Comprehensive Investigation report once it is completed upon request; this will highlight the areas that we as a Trust felt could be improved upon in future and the steps that we are taking to do so.

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 sincerely

[redacted]
[redacted]
Barts Health NHS Trust