Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Medical Director's Office

Mr S Singh, Medical Director (3630)
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RJC/js

15 April 2019

Miss S Haskey
Assistant Coroner
HM Coroners Service
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Miss Haskey

RE: Kathleen McGeary (deceased)

I write to you with respect of the Regulation 28 report issued on 26 February 2019 to the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust following the inquest into the death of Mrs McGeary held on 29 January 2019. The report was received by the Chief Executive's office and forwarded to me in order to provide a response.

I have been assisted in constructing this response by Dr Nicholas Mallaband, Divisional Director for Emergency Services, [redacted] Clinical Governance Lead for

Emergency Services and [redacted] Matron at Bassetlaw Hospital as well as [redacted] Patient Safety Lead who attended the Inquest.. Advice has also been sought from one of the Doncaster site based Care of the Elderly Consultants, [redacted] who kindly provided a review of the assessment that Mrs McGeary underwent while at Bassetlaw.

I would respond to the questions a follows.

1. **There was little evidence that Mrs McGeary (who suffered from dementia and was vulnerable) was fully and properly assessed, investigated, diagnosed and treated before discharge.**

   I report [redacted] opinion as follows:

   "I have reviewed the available online records for Mrs McGeary. I have not seen the paper notes. From the documentation available she appears to have presented with classical symptoms of lower urinary tract infection associated with delirium. I note a urine dipstick was negative but in the context of symptoms and the fever it will still be reasonable to treat as such as urinary symptoms are more strongly associated with UTI than is a dipstick. There were no features to suggest sepsis and examination from other sources of infection was carried out well. She has a documented normal neurological examination. She was not on any medication that was documented that would increase her risk of falling. – she was monitored overnight and underwent a therapy assessment and noted that her mobility was not at her base line - from the notes it would seem that short term increased support (in this case respite care) to allow the delirium to settle was appropriate. Admission to hospital for older people

with delirium is associated with poorer outcomes and where possible management should be limited to the community".

[redacted] goes on to provide an opinion as follows:

"I am of the opinion that she had a thorough assessment as appropriate and in an emergency department for a condition that would usually be managed in primary care".

I trust that you would be reassured by this independent overview and would apologise if perhaps the assessment that was undertaken was not accurately relayed to the Court at the time of the inquest.

I understand that during the inquest it was noted that a review of the past medical history from available hospital electronic notes (Medisec letter) was not undertaken which led to the ED team not being aware of her hyperparathyroidism. I would respond by saying that while, as heard in evidence, the Locum Doctor did not have access to Medisec, the Division have investigated this and found that the link between Symphony the system in ED and Medisec occasionally can be temperamental although all locums are provided with access to the Medisec system. On March 26 the current link button was removed from the Symphony system and replaced by a Medisec Viewer app that boots at the time Symphony is activated and is available for all to view and so far we have not experienced any problems with this following the update. Furthermore, communication has been sent out to all staff with respect to the importance of using this improved link.

With respect to the calcium level, one of the investigations that was carried out in ED was an arterial blood gas which showed an ionised calcium of 2.5 mmol/l which is above the normal limit (as expected in hyperthyroidism). On review of the previous records it was noted that the calcium was at the same level a year previously on a previous blood gas done in ED demonstrating that her calcium level was stable.

2. **No clinician took responsibility for discharge decision making. The recording of the identity of the discharging clinician was incorrect and the communication between clinicians and nursing staff was unclear.**

The decision to discharge the patient was made by [redacted] CDU Consultant on the ward rounds in the morning who clearly identified that the deceased was medically fit for discharge pending the outcome of the urine dipstick but required a RAPTS assessment. I am led to understand that should the RAPTS team at this stage have had any concerns they would have raised this with staff in ED and not continued with the discharge. I am advised that the team clearly stated that they had no concerns on this occasion. I am also advised by [redacted] Patient Safety Lead who attended the Inquest that while the Care Home Manager said that the deceased *"looked poorly when she arrived on an ambulance trolley and not in a wheelchair"* she was not immediately worried and was happy to accept Mrs McGeary for observation for 24 hours.

We have developed a new CDU(Clinical Decision Unit) standard operating procedure, which I attach, where it makes clear where responsibility lies for various aspects of

the patient pathway. It also has CDU pathway document that aids the communication between the main hospital department and CDU on admission. This has now been implemented.

3. **The electronic discharge summary was inadequate and no paper discharge summary was produced. No explanation was given for this omission.**

I confirm that all patients are admitted under a named Consultant in ED though the pathway of care would of necessity involve other Consultants as in this case [redacted]

It will therefore be the case that care may be delivered by an individual other than the named individual on the admission record. We have audited 50 discharges from CDU over the last 3 months and found that in 86% of cases there was evidence of a discharge summary in the electronic notes, either in electronic format or in paper format which was subsequently scanned. We accept that this is clearly below the standard that is required and we have initiated a discharge checklist with immediate effect while the CDU standard operating procedure was being finalised. The discharge checklist is attached.

4. **Mrs McGeary left hospital by arranged hospital transport without the antibiotics she had been prescribed for a suspected UTI. No explanation was given for this failing.**

We have not been able to find out why this has happened and we accept that this falls below the standards that the Trust aspires to and for which the Trust would like to issue a sincere apology to the family. However, as alluded to earlier, the Trust has introduced a discharge checklist to reduce the possibility of recurrence of such an

event. The Division will continue work on an electronic CDU discharge summary to further enhance the discharge process and aims to have this in place within the next 3 months.

I trust that this response to the Regulation 28 will reassure you that actions have been taken, and in particular, with respect to the discharge element of the patient pathway. However, should you require any further clarification please do not hesitate to revert back to me.

Yours sincerely

Mr R. J. Cuschieri MD ChM M Ed FRCS
Deputy Medical Director - Clinical Standards

Encs.

CC: [redacted]