NHS
Royal Free London
NHS Foundation Trust

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Private and Confidential

Mr Edwin Buckett
Assistant Coroner
St. Pancras Coroner's Court
Camley Street
London N1C 4PP

Date: 8 February 2021
Our reference: [redacted]
CQC reference: [redacted]

Dear Mr Buckett

Re: Prevention of Future Deaths Report following the inquest into the death of Hariharan Harichandra (died 19.12.2019)

I am writing to you to respond to the matters of concern raised in your Regulation 28 Report: Prevention of Future Deaths, following the Inquest in to the death of Mr Hariharan Harichandra. I would like to reassure you that we take any untoward death of a patient extremely seriously and I would like to thank you for providing me with the opportunity to respond to this Regulation 28 Report.

You raised a number of concerns in relation Mr Harichandra's care and treatment at the Royal Free Hospital, which has provided us with an opportunity to reflect, create, consolidate and strengthen our plans to prevent a similar death in the future.

Your report has been carefully considered by myself and my senior leadership team and reviewed across the Royal Free London Group through each hospital's Clinical Performance & Patient Safety Committee, (chaired by the medical directors of each unit).

The response to each concern can be found in the body of this letter below.

(a) **The error by the original clinician who interpreted the CT scan images of 5 December 2019 has not been explained properly.**

We fully recognise the reporting error of the CT scan. As a teaching hospital and as per standard UK practice, RFL radiology Specialist Registrars (SpRs) are in educational training. As part of their training they are required to interpret studies and place provisional reports. These are reviewed and modified when necessary by consultant radiologists, with feedback given to the SpR to complete the learning cycle. The secondary review by the consultant reduces the risk of perceptive or interpretive errors being translated into the final report.

An audit of cervical spine CT examinations performed over a 1 year period (27 January 2020 - 27 January 2021) reported by SpRs and then appropriately reviewed by Consultants provides evidence that this process is robust, with 99.8% of examinations being reviewed. The outstanding single case

not reviewed by a consultant was reported by an ST5 post FRCR SpR, deemed independently competent.

The SpR involved in this case was a 3rd year SpR at the time of this incident and has provided a statement of her interpretation of the case and reflective learning. It is evident that the doctor perceived the angulation in the neck but misinterpreted/presumed this as being chronic due to the patient's previous injury. This interpretative error was compounded by the lack of bone fracture in this particular case.

In her statement, the SpR raises having a neuro-radiologist available for a second opinion. RFL neuro-radiologists are always available during normal operational hours and were available at the time of the SpR reviewing the CT examination in December 2019. For out of hours emergencies, training SpRs have access to a Royal Free radiologist on-call and if they do not have suitable interpretive expertise, studies can be sent to an radiology outsourcing company (Everlight) that provide specialist opinions at all times. In addition RFL consultant radiologists now have home reporting stations such that immediate second opinions are available during on-call hours.

The Royal Free Radiology Training Program Director has stated that the SpR is an excellent trainee and that there have not been any concerns regarding her ability, conduct or behaviour. It has also been confirmed that the SpR has not been involved in any incidents or complaints other than this recent coroner's case. Furthermore, the SpRs e-portfolio demonstrates her exemplary record and she has provided her last two 360 feedback as examples of her overall standard of practice.

The SpR passed her FRCR 2B exam in October 2020 and has now moved to complete a fellowship in Paediatric Radiology at St Thomas' Hospital. She has a further post-CCT Fellowship organised in Canada in 2022.

The reporting error/discrepancy has been discussed with the Responsible Officers of both Health Education England and the Royal Free Hospital and no fitness to practice concerns have been raised, nor is there a material danger to other patients.

This particular CT cervical spine study will be included in the mandatory neuro-radiological training provided to all RFL radiology SpRs to ensure they are familiar with the pattern of injury that can happen in patients with a brittle spine secondary to diffuse idiopathic skeletal hyperostosis.

Learning from this case is not specific to SpRs and as with other radiological discrepancies, shared learning with all radiologists will occur via discussion at the RFL Radiology events and learning meetings (REALM) on 15.02.21 and 23.02.21. These meetings are performed as per Royal College of Radiologists guidance to allow anonymised constructive discussion of radiological discrepancies.

Please refer to appendix 1 and 2 for relevant evidence.

(b) The consultant radiologist who reviewed the CT scan images of 5 December 2019 should have noticed the clear and obvious neck fracture. Although there were 2 scans of 5 December 2019 to review, it appeared that the clinician most probably reviewed only one of the them. There ought to be a system in place which ensures that a scan review can only be completed if all the scans taken are reviewed by a second clinician.

All radiology SpRs have an allocated supervising consultant who oversees their practice to provide assurances that imaging is being interpreted and reported appropriately. This means that every examination that a radiology SpR reports should be reviewed and signed off by their supervising consultant, until such point that they are deemed independently competent.

In this case both the CT Brain images and CT cervical spine images were placed together in the CT Brain folder. Although all images remained visible to any reporter, the title of the folder may have been misleading and may have resulted in the reporter searching only for images of the brain.

In order to mitigate this risk, RFL Imaging has changed the process by which studies of this type are scanned. As a result when CT images of the brain and cervical spine are acquired for the same patient the images will always be placed in the appropriate but separate CT Brain and CT Cervical Spine folders. This will mean that to review and report the cervical spine images the reporter will have to open the cervical spine folder and will then be faced with images of the cervical spine only.

An audit will be conducted in three months' time to determine whether this new process has been firmly embedded and whether there are any other adaptations needed.

The current PACS (Picture archiving and communication system) managed by Carestream does not have the functionality to alert the reporter to images that have not been opened and this will be a consideration in any future PACS system procurements.

(c) The falls assessment tool was not properly completed or reviewed by staff

We recognise the importance of key critical information being appropriately shared between multi-disciplinary teams, and this is supported through the use of the online SBAR handover tool, and attendance by clinical teams at handover points, ward & board rounds and daily safety huddles.

The Trust utilises relevant assessment tools to support our nurses in understanding patients and their associated conditions. As well as the falls risk assessment tool, the admissions booklet contains a prompt for assessing a patient's mobility and directs staff to complete a further mobility care plan document where relevant.

Documentation audits have been on-going via the Perfect Ward app. This real time audit tool measures the approaches to a wide and varied group of safety metrics, which includes moving and handling, completion of the falls risk assessment and whether the risks are reassessed at appropriate points through the patients care. It is recognised that this data needs to be independently validated in order to provide assurance that results are accurate.

This was discussed at our the Senior Nurse / Matrons meeting on 4 February 2021 and going forward a team of senior nurses will dedicate one day a month from March 2021 to review the results submitted on the Perfect Ward app, (along with the documentation used to complete the audit) to ensure these reflect reliable results so that improvements can be determined and made.

These checks will also review whether assessments have involved patients and their carers in discussions about how to manage any specialist equipment.

The Perfect Ward data will continue to be reviewed at Divisional Quality & Safety Boards and at the hospital's Clinical Performance & Patient Safety Committee.

The trust's Frailty CPG (Clinical Pathway Group) has been working closely with clinical teams to embed the Clinical Frailty Score; a tool designed to systematically identify patients with frailty, when they attend our hospital. Trust wide implementation of this tool will support teams in the early identification of people who have frailty and will ensure we consistently deliver MDT focussed assessments and interventions that target frailty syndromes, such as falls.

Regrettably, some of this work has taken longer than intended to embed as the organisation became focused on its urgent response to both the first and second surges of the covid19 pandemic. Nonetheless, it is a high priority for the hospital and outputs are monitored through relevant committees. We have recently been able to adapt our SBAR online handover system to automatically prompt staff for a Frailty Assessment for patients over the age of 65.

With regards to the Falls Risk Assessment tool, this is based on national guidance and is broad in nature so as not to narrow clinical decision making. Whilst it is not possible to have a different tool for each patient, it does provide a space for the documentation of other identified risks that might apply to

a patient's individualised care plan. Used in conjunction with a comprehensive mobility assessment tool, this provides the clinical teams with a robust approach to falls prevention.

Successful implementation of this will continue to be monitored regularly through the use of the Perfect Ward audit app

In January 2020, the Royal Free Hospital introduced a weekly Falls Free Care Panel which is chaired by the hospital director of nursing. The purpose of this panel is to review falls incidents that appear to have caused moderate harm or above to our patients and to identify themes and develop robust actions to mitigate recurrence in the future.

Unfortunately, as mentioned above, much of the planned prevention work was put on hold during 2020 due to the Covid pandemic. However, from February 2021 onwards, the Free Falls Care Panel will be dedicating focused time to revisit the hospital wide falls prevention plan and will review how the plan is implemented and embedded in practice at ward level.

Updates on progress will be shared with the hospital's Clinical Performance & Patient Safety Committee bi-monthly (chaired by the hospital medical director) and fed up to the Clinical Standards and Innovation Committee – a Group non-executive led committee.

A quality improvement project to improve the management of patients with spinal injuries has been in place for over 2 years. Initially this focused on patients in the Emergency Department and acute care wards but there are plans to extend this to all inpatient wards. This work focuses on improved multi-disciplinary working for patients with spinal injuries and involves teaching from the therapy team to the ward staff. As part of this project, a spinal proforma and spinal injuries pathway were developed to make it clearer for all staff to see what is needed for each patient in terms of their spinal management. The document is available on our internal intranet system 'Freenet.

Please refer to appendices 3 to 11 for relevant evidence.

(d) Hospital staff have no training in how to assess and deal with private equipment brought from outside such as an electric wheelchair and the safety features of such devices.

It would not be practicable to provide training to staff on all the potential equipment that may be brought onto the ward from the community. However, we do recognise that there is a need for staff to feel confident in using such equipment safely when this scenario arises.

All of our inpatients undergo an initial assessment within six hours of admission to hospital, which leads to the development of a personalised care plan based on individual associated risks and needs. When fully undertaken, a scenario such as this would prompt a discussion with the patient / next of kin / care home about how the equipment is ordinarily used in the community, so that the clinical team can understand the needs of the patient and the safety features of the device.

Documentation of this is monitored through the Perfect Ward audit tool and following the launch of our validation programme (mentioned above) this will aid our leadership teams in quickly establishing the learning from outcomes and putting meaningful actions in place to change any practice or share good practice more widely.

We believe the approach described above will support teams in reviewing, documenting, and sharing the safety features of any external devices / equipment brought in from the community. We are also keen to work with our Commissioners and CQC to explore whether there are any other organisations within the UK that have managed to address this particular issue, which we can learn from.

In the meantime, the Trust's Mandatory & Statutory Training Committee will be tasked with reviewing how changes to the Manual Handling training might incorporate learning from this case and we have already provided the shared learning from this event at our senior nurses / matrons meeting.

Furthermore, we will be including this event as a case study within the nurse pre-ceptorship training which applies to all newly qualified nurses.

(e) By hospital staff not recording Mr Harichandra's adverse reaction to the naso-gastric tube insertion, future clinicians would have been unaware of this severe reaction when treating him and considering how his important nutritional needs should be met had he survived.

Having reviewed this event closely, we have established that the patient was seen by our lead nurse specialist for nutrition, as ward staff had experienced difficulties in gaining consent for the insertion of the naso-gastric tube. Addressing the patient's nutritional needs had become urgent and so the lead nurse specialist, along with a physiotherapist who had a good rapport with the patient, assessed the patient in order to understand more fully the difficulties in gaining consent.

The patient was noted to have a Miami J Collar insitu, and following discussions about the importance and reasons for the NG tube, the patient provided verbal consent. However, at each attempt to insert the NG tube, the patient became overwhelmed and withdrew his consent.

On the third attempt, the NG tube was placed by the opening of the patient's nostril and the patient closed his eyes. As he did not withdraw, the tube was advanced up the nasal passage to approximately 15cm, which would be roughly at the opening to the back of the patient's throat. At this point, the lead nurse stopped and was about to talk the patient through the swallowing process of advancing the NG tube down towards the stomach, when it was realised that the patient had become unresponsive. A crash call was put out immediately and resuscitation attempts were commenced.

Our staff are provided with training on the importance of good documentation, which includes all significant interactions with patients and the Legal Services Department also provides regular refresher training. Documentation also forms part of the professional requirements as a clinical professional, and we recognise that the failed insertion of the NG tube should have been documented.

It is worth noting that the lead nurse specialist for nutrition has been instrumental within the organisation for the development of the NG policy and its associated templated documentation, and is therefore fully aware of the need to document all NG care, including failed attempts. However, due to the patient's deterioration during the attempted insertion of the NG tube, the documentation of those attempts was subsequently overlooked as staff focused on the resuscitation of the patient.

Completion of NG tube documentation is audited via the Perfect Ward audit tool.

Please refer to appendix 8 for relevant evidence.

I very much hope I have provided you with assurances that we have learnt from the tragic death of Mr Harichandra and that we have put in place robust measures to prevent a similar event from recurring in the future.

If however you do have any further queries in relation to our response, please do not hesitate to contact me on the details provided at the top of this letter.

Yours sincerely

[redacted]
Chief Executive
Royal Free Hospital