Lewisham and Greenwich NHS
NHS Trust

University Hospital Lewisham
Lewisham High Street
London
SE13 6LH

[redacted]

www.lewishamandgreenwich.nhs.uk

Mr Andrew Harris
Her Majesty's Senior Coroner
Southwark Coroners Court
1 Tennis Street
London
SE1 1YD

11.08.2021

Dear Mr Harris,

Regulation 28 Report to Prevent Future Deaths
Re: Mr Abiodun Adisa Oritogun

I am writing in response to your report dated 10 June 2021, concerning the care provided to Mr Oritogun. Your report highlighted two matters of concerns which are listed below:

Whilst the Trust has an Action Plan to consider these matters, it has not been fully implemented a year after death and it is not clear that
a) it will ensure that patients with severe pancreatitis secure adequate monitoring and observations, whether in ITU, HDU or the ward
b) in determining the appropriate criteria for admission to ITU, that they will not be driven by ITU capacity constraints if it is clinically inappropriate to provide a lower level of care.

In response Lewisham and Greenwich Trust have reviewed this particular patient's case:

The Trust has a policy in place for the treatment of electrolyte abnormalities in general wards, and this includes the provision of cardiac monitoring (please see enclosed). Peripheral intravenous

electrolyte replacement is a safe practice that is adopted by hospitals nationally. Where central venous electrolyte replacement is required, this is provided by our Trust in a critical care setting (ITU or HDU). In Mr Oritogun's case, he received peripheral intravenous replacement of his low calcium level, and this was corrected prior to his death. He was also on a cardiac monitor in the general surgical ward during the time in which his calcium was being replaced intravenously.

Although Mr Oritogun was not referred to critical care for subsequent deterioration in his NEWS score, it is unlikely that his management would have changed through admission to ITU or HDU in the absence of organ failure. His nursing observation was enhanced through the provision of regular reviews by the Critical Care Outreach team (CCOT).

<u>Ensuring that patients with severe pancreatitis secure adequate monitoring and observations, whether in ITU, HDU or the ward</u>

Our criteria for admission to critical care (ITU or HDU) are the same as those adopted nationally. These criteria are derived from "*Guidelines on admission to and discharge from Intensive Care and High Dependency Units*" published by the Department of Health in March 1996; these guidelines are still applicable and current. The type of patients who require ITU care are unstable and have a requirement for multiple organ monitoring and/or support. Patients admitted to HDU are those requiring single organ support, or those who need observation and monitoring that cannot be safely provided on a general ward.

Where patients with severe pancreatitis require such observation, monitoring or organ support, they would need to be referred by their team of ward doctors or responsible consultant surgeon to the critical care team. This would result in an urgent review by an intensive care doctor (within no longer than 60 minutes) and either admission to critical care or advice on further management being provided on how to continue a patient's care and treatment on the general ward.

Where patients do not require a critical care admission, they can be managed on our wards with adequate monitoring and nursing observation, including cardiac monitoring if needed, and through the provision of enhanced nursing input through the CCOT team 24 hours a day.

In the period from 1st April 2018 to 31st March 2021, severe pancreatitis accounted for over 1% of our emergency critical care admissions, in line with figures from other critical care units nationally.

The mortality rate of this cohort of patients was just over 30%, and again this is consistent with other critical care units nationally.

In determining the appropriate criteria for admission to ITU, that they will not be driven by ITU capacity constraints if it is clinically inappropriate to provide a lower level of care

Critical care beds in both ITU and HDU are a finite resource. There can be times when demand outstrips available capacity. This is recognised nationally, and each NHS Trust is required to have plans available to deal with such capacity constraints.

We would never refuse critical care treatment to a patient based on the lack of availability of a critical care bed.

In the immediate response, we provide a critical care doctor (or airway trained anaesthetist) and a CCOT nurse to care for such patients wherever they may be, whether in the general wards, operating theatres, emergency department or elsewhere in the hospital.

These patients would then be moved to the safest area to continue provision of their critical care treatment, for example in our operating theatre complexes. This would also include the continuous presence of a trained doctor and critical care outreach nurse. As soon as a bed then became available in ITU or HDU the patient would be transferred there (and our aim is to achieve this within no longer than 2 hours from the time a decision is made that critical care admission is required).

As a secondary response, where an urgent bed is unlikely to become available within our own hospital critical care unit, we have a support agreement in place with the South-East London Adult Critical Care Network (SELACCN) and the Specialist Retrieval and Intensive Care Transfer service (SPRINT). The SPRINT team includes a critical care consultant, nurse and paramedic who can provide ITU and HDU level care in an ambulance, and operates its base from our own NHS Trust.

SELACCN is formed of the 6 hospitals in South East London (including Queen Elizabeth Hospital, University Hospital Lewisham, King's College Hospital, Princess Royal Hospital, Guy's Hospital and St Thomas' Hospital). The agreement between all these hospitals is that *'in the event of a critical care bed being unavailable in the local hospital, a patient transfer will be facilitated via SPRINT to the nearest critical care bed within the SELACCN'*.

In the year from 1st April 2020 to 31st March 2021, over 156 such transfers took place from Queen Elizabeth Hospital. During this same period, we admitted over 1,500 patients to our own critical care units, and an additional 90 patients who were transferred in from our partner NHS Trusts in other SELACCN hospitals.

I would like to assure you that the Trust has taken the concerns raised seriously and learning from this incident has been shared at the Trust Mortality Review Committee and Divisional Mortality and Morbidity meetings.

Should you have any further questions regarding any of the information provided in this letter or require any further information please do not hesitate to contact me.

Yours sincerely

[redacted], Medical Director
Lewisham and Greenwich NHS Trust

Enc:

- **Trust Clinical Guidelines for the Management of Phosphate, Calcium, Bicarbonate and Magnesium Imbalance in Adults**
- **Guidelines on admission to and discharge from Intensive Care and High Dependency Units – Department of Health**