MedPure
Healthcare Recruitment Specialists

RESPONSE

Regulation 28: Prevention of Future Deaths report Michael Anthony JAGGS (died 16.01.21)

CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. The agency nurse accepted in court that she should have sought prompt medical attention for Mr Jaggs and that she should have made a contemporaneous medical record of all his blood sugar readings. However, despite this sub optimal care, she said that she has not received any additional training from you following the incident. And she said that you did not ask her to draft a reflective statement, as the hospital trust had several times requested that you arrange. The trust has undertaken a great deal of work with its own staff to reduce the likelihood of such a failure in the future. I am extremely concerned that no similar learning is taking place within your agency.

TIMELINE OF EVENTS

19-Jan-21	Brief incident email received with a request for a factual statement of events on trust template. Incident email confirmed SI but no specific concerns around nurse
19-Jan-21	Complaint acknowledged to the trust. Email sent to agency nurse requesting a statement of events on trust template
02-Feb-21	Statement of events sent to trust for review
09-Feb-21	We requested an update on complaints from trust
02-Mar-21	Agency complaints team chase trust for an update
16-Mar-21	Agency complaints team chase trust for an update
23-Mar-21	Agency complaints team chase trust for an update
13-Apr-21	Agency complaints team chase trust for an update
04-May-21	Agency complaints team chase trust for an update
04-May-21	Full incident report received from trust. A request for a reflective statement is made at this point
05-May-21	Details of incident forwarded to agency clinical nurse for review

06-May-21	Clinical nurse calls nurse to discuss incident and reflective statement
26-May-21	Clinical nurse calls nurse to discuss incident and reflective statement

Nurse became unreachable after this time and we were made aware by the trust on the 28th September that an inquest took place.

We did re-engage with nurse shortly after to confirm a meeting with the trust.

We met with Deputy Chief Nurse, Deputy Director of People of Homerton University and nurse on the 21st October 2021.

During the course of this meeting, it was decided the nurse should self refer to the NMC.

CONCERNS AND REMEDIAL ACTION

1. Initial incident and statement request was to obtain a statement of events. Further information on this initial incident could have allowed us to act more accordingly. However;

    a. We have since outsourced our complaints to a 3rd party clinical complaints handling team.

    b. We have implemented a policy of obtaining a reflective statement at point of complaint being received to better identify any remedial action required.

    c. Our clinical complaints team are able to offer additional training where there is a need highlighted. This is provided to the nurse immediately. If face to face training is required, this is offered at the earliest opportunity.

    d. It was 98 days before we received a detailed version of events from the trust. We will look to escalate this much sooner should no response be forthcoming.

Additional training requirements have since been highlighted to nurse by our clinical complaints team and we have assisted the nurse is self-referring to the NMC.

We can confirm the NMC referral has taken place and we are supporting the NMC with their investigation.

[redacted]
Director

Monday 6th December 2021

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Complaint Process Flow Chart

5.4. ACI Complaint Process Flow Chart