NHS
The Leeds Teaching Hospitals
NHS Trust

7 February 2022

Your Ref:
[redacted]

Chief Medical Officer
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds
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Mr Kevin McLoughlin
Senior Coroner
West Yorkshire (Eastern)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

Dear Mr McLoughlin

INQUEST TOUCHING THE DEATH OF ALEXANDER THEODOSSIADIS (Deceased)

I refer to your correspondence of 3rd December 2021, regarding the inquest touching the death of Mr Alexander Theodossadis and the Regulation 28 Report to Prevent Future Deaths in respect of this case.

I can confirm that the contents of your Regulation 28 Report have been shared with the relevant staff to enable us to provide you with a comprehensive response.

In your report you highlight that your matters of concern were as follows:

(1) *Evidence was taken at the Inquest which indicated Mr Theodossiadis was moved from one hospital within the Trust to another, close to midnight on 25th January 2020. Despite being severely unwell with bacterial meningitis and a confused state he was not accompanied by a nurse escort, nor was any written handover instruction or briefing note provided for the nurses receiving him, in breach of the prevailing Trust handover guidance.*

(2) *Mr Theodossiadis remained in A&E for some 10 hours in total, despite the nature of his condition. Concern was expressed at the Inquest in relation to first, the absence of clear instructions regarding the need for a lumbar puncture within four hours of admission; secondly, a clear pathway to an appropriate treatment location; thirdly, any directions specifying the timetable in which action was required in response to a life-threatening condition.*

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(3) The inquest heard evidence that practice differs nationally on the need for a lumbar puncture in cases of meningitis. The absence of clear leadership on this issue nationally does not assist clinicians who may encounter this relatively rare, but serious condition.
(4) Despite spending 10 hours in A&E and displaying increasing signs of confusion he was seen to be trying to get of his hospital bed which created a risk of falls, no
(5) assessment of the falls risk was carried out. In consequence the receiving ward J27 at St James's University Hospital, Leeds were not forewarned of the risk of falls. He fell from his hospital bed within approximately 10 minutes of being placed in a side room on his own.

We have considered the contents of your report very carefully and our response is set out below.

(a) Transfer of patients

The Trust accepts that Mr Theodossiadis did not have a nurse escort when he was transferred to St James's Hospital. This would have facilitated a handover of care to the Ward J27 nursing team, including the fact that the patient was at risk of falls.

Given the large volumes of patients within both Emergency Departments across the city, it is sometimes not possible or practicable for a nurse to personally escort patients for a cross-city transfer. To do so would deplete the department of an experienced nurse for over an hour, with the potential to compromise care of other patients waiting for treatment. Instead, patients will be handed over to the care of the Yorkshire Ambulance Service who will facilitate safe transfer. For transfers within the same hospital, a now improving staff position means that, wherever possible, the patient will be accompanied to the new ward or clinical area by a member of the ED staff so that a direct handover can be facilitated.

For cross-city transfers we must ensure a robust handover of care between nursing staff in the ED and on the receiving ward. This may take the form of a telephone conversation but this should always be accompanied by a written handover document. Currently in the Emergency Department this takes the form of a written document that is then scanned into the electronic patient record (PPM+). The Trust is currently trialling a stand-alone electronic transfer document and it is anticipated that this will be rolled out to all areas of the Trust in due course.

The Trust is working towards 100% compliance with use of the transfer document and a rolling audit programme has been taking place for over 12 months to monitor progress. The latest audit figures are encouraging but the Trust recognises that this improvement must be sustained and therefore the process of regular audit will continue. In addition, we are

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seeking an understanding with YAS that they will not accept patients for transfer without a handover document which clearly records the patient's falls risk.

(b) Lumbar puncture

The Trust notes the Coroner's concerns regarding the need for lumbar puncture. It is recognised that whilst there is national guidance on the indications and timing of lumbar puncture, practice is varied throughout the country. This may be due to a number of factors:

1. Lumbar puncture is a diagnostic test rather than a treatment. As in the case of Mr Theodossiadis, antibiotics were administered shortly after he attended the Emergency Department in line with Trust and national guidance. In other words, treatment was commenced as soon as the team were suspicious of a serious pathology such as sepsis or meningitis. Had a lumbar puncture been carried out first and the results awaited, his life-saving treatment would have been delayed.
2. In this context, the main purposes of the lumbar puncture are to confirm the diagnosis of meningitis, to differentiate between bacterial and viral meningitis, and to guide antibiotic therapy later in treatment. Lumbar puncture can be a painful procedure and is difficult to carry out if the patient is confused or restless. It is a sterile procedure which requires an experienced practitioner to carry it out safely. In a busy emergency department this can be a logistical challenge. If the procedure is delayed, its potential benefits begin to diminish as treatment has already commenced and the chances of culturing a specific organism are reduced.
3. Lumbar puncture is not without risk, with serious complications well recognised. It is contraindicated where there is evidence of coagulopathy or raised intracranial pressure. In practice this means that an unwell patient with possible meningitis will require blood tests and a brain CT scan reported by a radiologist prior to the lumbar puncture being carried out. These require some time to be performed and the results then processed, which again in the context of a busy emergency department will lessen the value of the test being carried out at a later point.

However, the Trust does recognise the potential value of an early lumbar puncture (LP) and is endeavouring to provide this diagnostic test where possible. Specifically, a lumbar puncture may allow antibiotic therapy to be rationalised, with broad spectrum treatment being replaced with more specific antibiotics. As such the Trust has developed a standard operating procedure (SOP) with the aim of carrying out a lumbar puncture within one hour wherever possible. At St James's University Hospital during daytime hours (8am-8pm), the patient will be transferred to the Same Day Emergency Care (SDEC) unit adjacent to the Emergency Department where the LP will be carried out by a medical registrar or Advanced Practitioner. SDEC is a more suitable environment for the LP to be carried out as it is a less congested and more private area where sterility can be more easily maintained for the procedure to be carried out safely. The SOP should mean that patients with suspected

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meningitis spend much less time in the Emergency Department and can have the lumbar puncture performed by an experienced practitioner in a timely fashion. It is hoped that in due course the service will be available in the St James's SDEC 24 hours per day. Further consideration is being given to how a similar arrangement could be provided at the LGI site.

(c) Patient falls

It is recognised that the Emergency Department is a high risk area for patient falls as many attenders are frail or have pathology that increases their risk. This of course includes patients such as Mr Theodossiadis who are confused because of infection or intracranial pathology.

The Trust would like to reassure the Coroner that it takes the risks of falls within the Emergency Department very seriously. All patients within the department should have a falls assessment recorded. As in the case of the handover document, compliance is continuously audited. The latest audit figures demonstrate excellent compliance with the tool, but the department recognises that this must be sustained to prevent future harm to patients.

I can confirm that Mr Theodossiadis did have a falls risk assessment completed at 13.14 by the assessment nurse which was entered on to the ED electronic patient record Symphony. He was not deemed to be a falls risk. However when he later became more confused, his assessment should have been repeated. The senior members of the ED nursing team fully recognise the need for repeated assessments when the patient's condition changes and are working hard to ensure that this practice is embedded within the department.

We are monitoring and auditing compliance regarding safety and dignity checks within the department on a daily basis. This includes identifying, risk assessing and monitoring concerns for patients who are at risk, including falls.

We have improved our education and understanding of patient risk across the department regarding falls and the importance of rapid and correct assessment of patients on arrival, and the on-going assessment during their stay in ED. The risk of patient falls is continuously highlighted within the Emergency Department. Staff have regular safety huddles where vulnerable patients are discussed. In addition, dedicated 'falls awareness' boards have been placed throughout the departments to raise staff awareness and promote best practice. Practical initiatives that have been implemented include the provision of yellow socks for patients at risk of falls to provide a clear visual cue for staff. In addition, we now request additional Clinical Support Worker bank shifts to meet enhanced care needs of our vulnerable patients.

In the event that a fall incident does occur, all falls are reported on the Trust's incident reporting system Datix and a root cause analysis (RCA) is carried out for each case to identify learning points. The Head of Nursing for the Emergency Department reports directly

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to the Executive Team including the Chief Medical Officer and Chief Nurse at the Weekly Quality Meeting for assurance. She reports on a number of key metrics including falls within the department.

Thank you for bringing these matters to my attention. I do hope that this response has assured you that the Trust has given careful consideration to the matters of concern you have raised.

If I can be of any further assistance please do not hesitate to contact me.

Kind regards

Yours sincerely

Dr [redacted]
Chief Medical Officer and Deputy Chief Executive
Leeds Teaching Hospitals NHS Trust