Barts Health
NHS Trust

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[redacted]

Chief Medical Officer
[redacted]

www.bartshealth.nhs.uk

27th April 2022

PRIVATE & CONFIDENTIAL

Ms Nadia Persaud

HM Coroner

Dear Ms Persaud,

RE: Regulation 28: Report to Prevent Future Deaths

I write in response to the recent Regulation 28: Report to Prevent Future Deaths notice regarding the care of Vijaykumar Gadhavi

Mr Gadhavi suffered from chronic pancreatitis, mild learning disability and possibly a persistent somatoform pain disorder (the latter was under investigation at the time of his death). In July and August 2020, whilst an inpatient at Whipps Cross Hospital and whilst under enhanced (1:1 care), Mr Gadhavi carried out a number of self-harming acts. These included overdoses and an attempt to jump from a hospital bridge.
On one occasion in August 2020, the member of staff allocated to provide 1:1 care to him, was found to be sleeping. In September 2020, Mr Gadhavi required admission to Whipps Cross Hospital again. There was no alert on his medical records to alert staff to the need for a risk assessment and risk management plan. Fortuitously, he was recognised by a member of staff who had cared for him previously and enhanced care was put in place. There were a number of breaches of the enhanced care policy and sadly Mr Gadhavi was able to take a fatal overdose of medication whilst he was in inpatient.

The matters of concern raised in the Regulation 28 notice and our response to them are as follows:

1. Datix reports were generated for the multiple self-harming incidents in July and August 2020. There was no evidence at the inquest, that action and learning had been put in place as a result of these incidents.

Our serious incident investigation identified a number of care and service delivery problems related to My Gadhavi's admissions in July and August 2020. We acknowledge with deep sadness that our response to the concerns reported on Datix was not adequate to prevent Mr Gadhavi's further attempt to take his own life. With the knowledge that the systems within an acute general hospital have not historically been focussed on the prevention of intentional self-harm, we have considered how we can in future provide better individualised care for patients with complex mental and disability care needs, and our progress is shared in our responses below.

2. Despite the multiple risk incidents and foreseeability of future hospital admissions, there was no alert or flag placed on Mr Gadhavi's records to alert new staff to the complexities and risk in his presentation.

We have established a whole-trust task and finish group to consider how to implement a flag relating to risk of self-harm. The group includes safeguarding practitioners, mental health, legal, information governance and ICT colleagues. The group is working through a number of ethical and practical questions, which include a concern about stigmatising patients.

3. Despite awareness of the previous overdoses on the ward, there was no itemised property list, including a list of medications.

The ward matrons have developed an improvement plan for accurate documentation of patient property which includes regular audits of the electronic patient check list and patient property kept on the ward, and working with pharmacy to increase medication reconciliation.

4. The recommendations by the learning disability nurse were not fully put into practice and there was insufficient involvement of his family.

The learning disability nurse will conduct awareness and ward teaching sessions to improve compliance with prescribed care plans. We have also identified the need for more integrated documentation between the mental health and acute hospital patient record systems, and have agreed with the psychiatric liaison team that they will copy their documentation on EMIS onto the trust's CRS system.

5. There were multiple breaches of the Enhanced Care Policy. There was no risk assessment by the allocated nurse; no consideration of the need to break up the shift of the 1:1 carer and no hourly observations kept by the 1:1 carer.

During Mr Gadhavi's admission in September 2020 nursing staffing gaps were exacerbated by staff absence and vacancies directly caused by the COVID pandemic. The hospital has a robust system for distributing nurses to mitigate risks due to staffing, but at that time was only able to reduce rather than remove the risk, and this was reflected in our hospital risk register. This meant that staff had to adapt their practice flexibly to best meet the risks and pressures on the ward on the day. Compliance with completion of risk assessments is audited at trust level. To reinforce the importance of complying with the implementation of the Enhanced Care Policy, our hospital Director of Nursing has reminded all Ward Matrons to monitor compliance with hourly observations during nursing handover.

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Thank you for communicating your concerns to us - we believe that our services will be safer as a result of the action we are taking to address them.

Yours sincerely,

[redacted]

Chief Medical Officer
Barts Health NHS Trust

CC: