NHS
Barts Health
NHS Trust

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Deputy Chief Medical Officer
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Date: 9th October 2020

Private & Confidential
Mr Graeme Irvine
HM Assistant Coroner for Inner London North

Dear Mr Irvine,

RE: Regulation 28 Prevention of Future Deaths Report: Moses Victor Boardman

I write in response to your Regulation 28: Report to Prevent Future Deaths, dated 11th August 2020. Your concerns are related to the discharge of Mr Boardman from the Royal London Hospital in December 2019.

At the inquest you raised 6 matters of concern for Barts Health NHS Trust and Tower Hamlets Local Authority.

1. **The absence of a clear computerised record in the RLH departure lounge explaining the change of address.**
   This issue was identified as part of the trusts Serious Incident (SI) investigation and action was taken at the time. The departure lounge changed its practice to ensure that the staff document in the patients electronic record in line with trust practice. Confirmation of this has been detailed within the departments most recent version of the Standard Operating Procedure (SOP). At the inquest you were shown this SOP in draft form but I can update you now to say that it has now been signed off by the Royal London Hospital's Executive Board.

   At the inquest you asked for evidence of this change in documentation and whether any audits had taken place. As an action in light of this query the departure lounge will now complete documentation audits in line with trust practice for clinical areas to provide assurance that this is being completed.

2. **The lack of a clear safeguard to ensure that a vulnerable patient is discharge to the correct address.**
   Again, action was taken for this concern at the time of the SI Investigation. The departure lounge clarified in their SOP that when a patient is discharged via hospital transport the Discharge Lounge staff will confirm with the Patient Transport Service driver the location and agreed destination for the patient. Any discrepancy must be escalated to the ward area for confirmation and Senior Clinical Site Manager if this discrepancy persists. Again, as per point 1, the staff will document this within the patients electronic medical records.

3. **The failure of RLH transport staff to properly assess the suitability of the venue that a patient is being taken to.**
   The trusts transport team have a safeguarding process for completion when a discharge destination raises concerns. At the time of the incident the process that the crews follow was similar to the rest of the Trust, they will raise both safeguarding and adult care concerns using the safeguarding form which is then uploaded onto Datix (our risk management system for reporting adverse incidents) by an assistant manager. However, if the crew member is on scene and is worried about heat, light, care package, or patient safety then they will call control to return the patient to hospital. Direction is then taken from the ward, if they are able to come back to the ward, then they take the patient there, if the ward has already allocated the bed to another patient, then the patient is taken back to the ED (Emergency Department).

   As an action the Associate Director of Transport has arranged to review the current safeguarding processes in place and this process will be amended according to their findings.

4. **The responsiveness of the care provider commissioned by LBTH to escalate the fact that they had been unable to reach Mr Boardman for his first 3 visits**
   This is a matter for LBTH to respond to

5. **The proper monitoring of patients on RLH ward 14f who have been assessed as being "fed at risk". Specifically, why was a vulnerable patient left with unsuitable foods within his reach.**
   The trusts clinical guidelines "Guidelines for Best Practice: Eating and Drinking at Risk (Adults)" was approved in September 2019. This guideline was developed by Speech and Language Therapy and lays out the roles and responsibilities of the whole multidisciplinary team (MDT) in managing risk feeding in patients. The guideline contains a decision making tool as well as explaining the role and importance of patient preference and choice in the decision making alongside the MDT. We have reviewed this document and recognise that it is silent on the counselling of patients and their relatives as part of the process for managing their risk. As an action now we will review this guideline and make amendments to include details regarding this.

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6. **The RLH failure to commence CPR when a potential reversible cause for collapse existed that would override the effect of the DNAR order**

   After the initial Serious Incident (SI) investigation we understand there was concern about Mr Boardman choking on fruit, therefore a second investigation was carried out to look at this particular potential incident.

   It' s clear from staff statements that Mr Boardman had taken a bite out of the kiwi fruit before it was removed at 2000. At 0200 he is heard coughing and when the nurse attends she finds him unresponsive. Although he has a DNR order the cardiac arrest team is called. They arrive and find him unresponsive with agonal breathing. This type of breathing would not occur with any form of upper airway obstruction; it was also six hours after he had taken a bite of the kiwi fruit. This related to poor blood flow to the brain, fitting with the description of him having an impalpable pulse. In view of no immediate reversible cause, such as an airway obstruction the DNR order was followed and the gentleman passed away peacefully two hours later.

Thank you for bringing your concerns to my attention. I trust that you are assured that I have taken them seriously and that the hospital has investigated them appropriately. I am very happy to discuss or clarify any of the above points.

Yours sincerely

Dr [redacted]
Deputy Chief Medical Officer