Barking, Havering and Redbridge
University Hospitals
NHS Trust

Legal Services Department
Queen's Hospital
Rom Valley Way, Romford, RM7 0AG

[redacted]

Ref: 13171727
20 July 2022

Private & Confidential
Mr G Irvine
HM Senior Coroner
Walthamstow Coroner's Court
Queens Road
London
E17 8QP

Dear Sir,

Regulation 28 Report on the death of Elizabeth Margaret Mills-Trust's Response

Thank you for your Regulation 28 Report of 25 May 2022. In your Regulation 28 Report to Prevent Future Deaths dated 28 May 2022, you set out the following matters of concern:

1) The poor standard of medical record- keeping and documentation did not allow a clear understanding of whether the Trust policy on "Do not attempt CPR" orders was followed properly. Family members assert that the process was not properly engaged and their views were not explored.

2) During the final hours of her life, Mrs Mills required increasing levels of oxygen therapy. Mrs Mills was agitated and repeatedly removed a Venturi mask. Medical and Nursing staff left Mrs Mills in a side ward in the care of her husband, relying upon him to ensure her mask remained in place.

3) Unexpected events that impacted upon Mrs Mills' care were not investigated by the Trust in the form of a Serious Incident Investigation.

In the opinion of HM Acting Senior Coroner, action should be taken to prevent future deaths and he believes the Trust has the power to take such action.

Trust's Response

The Trust has carefully considered the concerns raised by HM Acting Senior Coroner in his Regulation 28 Report and guidance has been sought from various specialists within the Trust as to the concerns raised by the Learned Coroner in his Regulation 28 Report.

The Trust's response to the concerns is as follows.

1) The Trust has a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy No 2018/ PC/238 dated January 2018. The policy acknowledges that effective communication is absolutely essential to ensure that decisions about CPR are made well and understood clearly by all those involved. It states that CPR is a medical treatment and as such, whether or not to attempt CPR for a patient is a medical decision which rests with the senior clinician responsible for the patient's care. Making a decision not to attempt CPR that has no prospect of success does not require the consent of the patient or those close to the patient.

   However, there is a presumption in favour of informing the patient of such a decision and the Trust policy requires clear, accurate and honest communication with the patient and those close to them. If the patient or those close to them disagrees with the DNACPR decision, a second opinion will be offered. Any decision about CPR must be communicated clearly to all those involved in the patient's care and documented. Trust policy requires each decision about CPR to be subject to review, based on a person's individual circumstances and it will be sufficiently frequent to allow a change in decision in either direction in response to a person's clinical progress or lack of it. Triggers for review include any request from a patient or those close to them, any subsequent change in the patient's clinical condition or prognosis and transfer of the patient to a different location. The final decision regarding whether or not to attempt CPR rests with the healthcare professional immediately responsible for the patient's immediate care.

   The Trust is satisfied that the current policy (attached to this response) clearly sets out the need for clear communication about DNACPR with the patient and those close to them, together with the need for clear documentation on DNACPR decisions and the requirement for regular review of DNACPR decisions. I am sorry that the documentation in this case did not allow a clear understanding of whether the Trust policy on DNACPR orders was correctly followed. The Trust intends to ratify a new DNACPR policy in August 2022. Policies undergo rigorous drafting with stakeholder engagement, to aid richer development. Policies are disseminated across the Trust in discussion by virtual meetings, relevant forums such as Quality and Safety meetings, emails cascaded by Divisional teams and through briefings by the Communications Team.

2) Medical staff leaving Mrs Mills in a side ward in the care of her husband, relying upon him to ensure the mask remained in place when she was agitated and removing the mask.

   The Trust's expectation is that if a patient is agitated and removing an oxygen supply, a member of nursing staff should stay with the patient. If it was a long- term issue, such as a patient with confusion or dementia, the patient would be assessed to see if they require one to one nursing

care to assist with giving oxygen therapy safely. However, in an acute situation, such as EM's situation, where the patient deteriorates quickly, it may not be possible to facilitate extra staff and the focus would be on providing immediate treatment. It is expected that nursing staff would escalate the fact that a patient is agitated and removing their oxygen mask to the doctor/ nurse in charge. It would be reasonable for a nurse to leave the patient for a short period in order to communicate with colleagues/ escalate any concerns, if the patient was settled. Patients' relatives can be very helpful in reassuring and calming patients to assist with giving therapies such as oxygen but there would not be an assumption that they would deal with administering the therapy. The expectation is that if a nurse leaves the patient, they will notify the patient/relative/visitor of where they are going, how long they will be and to call, if assistance is required. Nursing staff will be reminded of the expectations involved in nursing patients receiving oxygen therapy.

3) Unexpected events that impacted upon Mrs Mills' care were not investigated by the Trust in the form of a Serious Incident Investigation.

The incident was reported on 26 March 2021 and it was flagged as a potential SI matter by the Quality and Safety 'Q&S' Team. A review was undertaken by the ED Matron and by the Surgical Division. This was held with multidisciplinary key stakeholders from including pharmacists, matrons, registrars, clinical leads, consultants and consultant surgeons from Gastroenterology, Breast and General Surgery, Adult Day Unit and Theatres. The reviews established that the correct morphine doses were given to EM at appropriate times and the matter was not an SI matter. The Q&S team removed the potential SI flag. Separately, EM's husband pursued a complaint regarding her care and management which was not upheld and the husband declined a meeting with the Trust. The Trust teams considered that the incident did not require escalation to SI, as morphine was given, EM had respiratory distress and responded to opioid antidotes, leading to the impression of opioid sensitivity. I trust this clarifies why the Trust did not undertake an SI investigation. The Trust has already introduced incident reporting of all new inquests to formalise divisional review. It has also introduced an independent mortality review for all new inquests. A Medical Examiners team is being implemented across the Trust to ensure scrutiny of deaths, not investigated at the outset by the Coroner, to provide further reassurance regarding the appropriate investigation of deaths at the Trust.

I would be happy to meet to discuss this response if that would be helpful to the Coroner.

Yours sincerely,

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Chief Executive

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