E: [redacted].

Date: 9 September 2022

Ms A Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Darren Jones 22/10/21

Thank you for your Regulation 28 Report dated 17/07/22 concerning the sad death of Darren Jones on 22/10/21. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr. Jones family for their loss.

Thank you for highlighting your concerns during Mr. Jones Inquest which concluded on 6 June 2022. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention but it is also very important to ensure we make the necessary improvements to the quality and safety of future services.

The inquest concluded that Darren's death was a result of 1a) Sepsis; 1b) Urinary Tract Infection on a background of long-term catheterisation; II) Chronic bladder outflow obstruction, Chronic Kidney Disease. Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk future deaths will occur unless action is taken.

I hope the response below demonstrates to you and Mr. Jones family that NHS GM has taken the concerns you have raised seriously and will learn from this as a whole system.

This letter addresses the issues that fall within the remit of NHS GM and how we can share the learning from this case.

The evidence was that the District Nursing Teams were under significant pressure which impacted the support and care they could deliver
The key issues in this case were in relation to nursing practice, specifically documentation and the failure to direct the patient to the most appropriate setting within the hospital.

Documentation
It was identified that documentation standards were not achieved in this case; Emis (clinical system) entries were not made following the second attendance and clinical observations were not recorded prior to the decision to refer Mr. Jones to the hospital.

The team has been reminded of the importance of accurate and timely completion of all patient records and there is now a monthly review of 10 sets of notes to ensure that standards are achieved and maintained.

The locality has confirmed that 1:1 feedback has been given to all of the nurses involv[redacted] standards of documentation shared across the Stockport District Nursing Service during daily huddles, team meetings, 'message of the week' and the divisional lessons learnt newsletter.

Referral into hospital
In circumstance where a patient is transferred to Stockport NHS Foundation Trust (Stepping Hill Hospital) due to failed catheter insertion, the correct pathway is for the patient to be admitted and reviewed within the Surgical Assessment Unit (SAU) as opposed to the Emergency Department. In this case Mr. Jones was referred into the Emergency Department which was not the appropriate pathway for him.

The team has been reminded of the appropriate pathway and management of a patient needing admission due to failed catheter insertion.

In response to the general question of pressures within the District Nursing Service, there are pressures across the system including district nursing services. However, the findings in this case were identified to be around individual practice and awareness as opposed to being due to pressures. That said, it can be realistically accepted that wider pressures may have had an impact.

The Action Plan resulting from this case has been reviewed and the locality is satisfied that a detailed review of the case has taken place and that the necessary actions have been taken to reduce the likelihood of a similar situation arising in the future.

Mr. Jones had significant learning difficulties which were not recognised at the hospital to ensure that he was provided with support and to ensure that an IMCA was put in place to ensure his best interests
In circumstances where a patient with significant learning difficulties is admitted to hospital, there is a robust process of referral to the safeguarding team for support and guidance; this is to ensure that the patient is supported and appropriate services, including the involvement of an IMCA made available to the patient. In this case, regrettably, the team were not contacted / alerted to the admission.

In response to this omission, arrangements were made for safeguarding supervision for the specific purpose of learning from this episode of care and to ensure improvement across the team. The learnings here have been fed back to the whole of the Victoria Nursing Team.

We are satisfied that there is a robust process in place for the support of patients with learning difficulties but acknowledge that the process failed on this occasion which is highly regrettable. Appropriate steps have been taken to ensure wider team awareness for the benefit of future patients.

The inquest heard that there was a dispute between two local authorities in relation to training re catheter care and that this impacted on the provision of respite care and the health and wellbeing of Mr. Jones
This is a matter for the local authorities involved to address; what can be confirmed is that the District Nursing Team are trained in catheter care

No LeDeR Report appeared to have been commissioned in relation to Mr. Jones
A LeDeR notification had been made to the system in respect of Mr. Darren Jones. The review was put on 'hold' as per national and regional guidance as the case was being heard at inquest.

Previous instructions were that in circumstances where a Coroner requests a review be completed, localities would be informed directly by the Coroner's Office. Such a request was not received in this case.

4th Floor, Piccadilly Place, Manchester M1 3BN

A copy of the overall Action Plan resulting from this case is attached which I hope will offer reassurance.

Actions taken or being taken to share learning across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester System Quality Group. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums.

In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. NHS GM is committed to improving outcomes for the population of Greater Manchester.

I hope this response demonstrates to you and Mr Jones family that NHS GM has taken the concerns you have raised seriously and is committed to work together as a system including our service users, carers and families to improve the care provided.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

Interim Chief Nurse
GM Integrated Care

4th Floor, Piccadilly Place, Manchester M1 3BN