The Leeds Teaching Hospitals NHS Trust

Date: 4th November 2022

Chief Medical Officer and
Deputy Chief Executive
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds
LS9 7TF

[redacted]

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 JOHN FRANCIS HEFFRON (deceased)

I write in response to the Report to Prevent Future Deaths dated 18th August 2022 sent to Leeds Teaching Hospitals NHS Trust following your investigation into the death of Mr John Francis Heffron and the inquest concluded on 17th August 2022.

The Regulation 28 Report has been shared with relevant staff in the Trust and this response provides details of action taken by the organisation in response to the concerns set out in it.

In your report the matters of concern are set out as follows:

(1) There was a delay between the patient being found in an unresponsive condition and CPR being initiated. Although the evidence as to the material times was not entirely reliable the Trust's investigation indicated that the patient had been found unresponsive around 1.15am, yet the statement of the registrar on duty stated she was called at 1.30am. There was then an interval of time whilst the patient's DNAR status was ascertained from the computerised medical records.

(2) The lady working as a bank nurse in the ED who found the patient unresponsive admitted to the Trust's investigator, she was not familiar with the crash call system. She did not press the buzzer to initiate a crash call. The extent of her training in CPR was unclear. It is understood she normally worked on a part-time basis in an outpatient unit.

(3) The experienced nurse alerted to the situation also did not press the crash call buzzer. She appears not to have examined the patient, but instead telephoned the sister in charge of the ED to report the patient had died. She admitted to the Trust's investigator that she was overwhelmed.

(4) When CPR was commenced, a return of spontaneous circulation was achieved at 1.50am. A CT scan at approximately 4.30am indicated a hypoxic brain injury had been sustained.

(5) Evidence taken at the inquest indicated the collapse and/or death of a patient in the ED is known to occur sometimes. It is a foreseeable risk. Hence there is a need for the nursing staff to be trained and familiar with the emergency systems in place, in order to be able to respond appropriately.

(6) It was unclear what steps had been taken by the Trust prior to 12th December 2021 to establish:
   i. the nursing qualifications of bank and/or agency staff permitted to work in the ED.
   ii. whether bank and/or agency staff hold appropriate and current training in resuscitation procedures.
   iii. whether a suitable induction system was in place to ensure bank and/or agency staff were familiar with the crash call system.

(7) The Trust saw the need to initiate a "Serious Incident Investigation" but allocated this work to a person:
   i. present in the ED at the time of the incident and thus not independent of the events being examined.
   ii. who had not been trained in such investigations save for a one-day course some five years previously and had never undertaken one of this nature before.
   iii. who spoke to the staff involved during the shift on the night of the incident, only when time permitted, alongside their other work. No written statements were obtained. In consequence, the precise chronology of events is unclear.
   iv. no context was provided which may have enabled an assessment of the workload or staffing levels in the ED at the material time.

For these reasons the inquest felt unable to rely upon the conclusions reached in the Serious Incident Investigation Report

(8) It is acknowledged that some additional refresher training has been carried out since this incident. There is, however, no system of audit, spot checks or dip testing to verify that bank and/or agency nurses are actually familiar with the essential procedures relating to crash calls.

(9) It was unclear whether the Trust's contractual arrangements with nursing agencies stipulate the requirements for those supplied to:

   i. be professionally qualified.
   ii. have current training to specified standards.
   iii. have undergone appropriate induction to the ED.

We have considered these carefully and our response is set out below.

(1) The Trust acknowledges that there was a delay in CPR being commenced after the patient had been found in an unresponsive condition and there were discrepancies in the evidence for the inquest about timings. However, the senior sister stands by the account that she gave in court i.e., that she had been contacted at 01.15am, after the doctor had been approached, and that she attended immediately after the call to her, by which time CPR was being undertaken. In her statement for the inquest, she explained that her discussions with the relevant team members afterwards indicated that CPR had been started within 30 to 60 seconds of the patient being found. The Trust understands that it was Dr Binbay's recollection that she had been contacted at 01.30am however this was not supported by other staff members. Unfortunately, the doctor was not called to give evidence at the inquest and therefore this issue could not be explored any further. Whilst respecting your findings at the inquest, the Trust does not accept that the period of delay in commencing treatment for the cardiac arrest with CPR was as long as 15 minutes. It is accepted however that obtaining statements from staff during the incident investigation would have provided more robust first hand evidence.

(2) The bank nurse on duty in the ED on 12th December 2021 was up to date with the Trust's mandatory and priority training for all nurses. She had completed the Trust's level 1 Resuscitation training course. This meets the statutory and mandatory training requirements and learning outcomes for Resuscitation level 1 in the UK Core Skills Training Framework (UK CSTF). The course objectives are as follows:
   - To recognise when someone's heart has stopped (cardiac arrest).
   - The best way of getting immediate help.
   - How to carry out chest compressions.
   - What to do if an adult is choking.

(3) The Covid 19 pandemic and its legacy have had a profound effect on the work of the Trust and both of its Emergency Departments. It has impacted on the numbers of patients attending; the way in which they are

managed in the departments, (and elsewhere in our hospitals), and the workforce required to assess and treat them. In response to this we have had to expand the size of our Emergency Department footprint; increase the senior leadership presence in the department, with band 7 nursing cover 24 hours a day alongside new Matron leadership and allocate significant investment into the nursing workforce to help with the care and treatment of our patients. There is a robust Bronze Command structure to facilitate efficient escalation of concerns about resourcing in and out of hours and there is an internal reporting system known as SafeCare that enables staff to flag workforce issues as they arise. This increased resource has improved the support the Trust provides to staff working on the frontline and is intended to minimise instances of individual members of staff feeling overwhelmed by their workload.

It is accepted that in this case there were deficiencies in the response of the experienced nurse on duty to an emergency when she failed to press the crash buzzer or examine the patient after finding him in a state of cardiac arrest. However, the same nurse did seek medical advice immediately from a doctor, in addition to telephoning the sister in charge. The recollection of the staff member involved at the time is that both responded to her requests for assistance very promptly. Additional support and refresher training was provided to the nurse following the incident. It is envisaged that with the changes that have been made which are referenced above and below, the likelihood of a recurrence of such an incident are very low.

(4) Your summary of the resuscitation and investigations conducted after it is noted.

(5) All nursing staff employed by the Trust as substantive members of staff attend corporate induction training on their first day of employment. Within 28 days of starting work they must also complete local induction within their specific department or area of work. To evidence local induction there is a standardised template that must be completed which details the procedures that must be covered with the new starters; this includes action to take in an emergency, and local procedures for resuscitation.

In the Urgent Care Clinical Service Unit new members of staff receive a new starter booklet which explains the mandatory and priority training they must undertake, with emphasis on its importance to the work they will be doing. All new nurses in the ED work in a supernumerary capacity for 6 weeks while they complete their basic training and familiarise themselves with the department and the processes in place within it. This system was in place at the time of Mr Heffron's death.

The training and qualifications required for agency and bank nurses working in the ED are set out below.

(6) In December 2021 the Trust followed a framework employment checklist for temporary workers on temporary assignments, to establish their qualifications and training prior to them starting work in the ED. This still remains the case. Staff allocated by the preferred provider to work in the EDs should only be staff with prior ED experience. Checks made cover the individual's qualifications, skills and experience, their DBS status and completion of the Trust's mandatory and priority training (including refresher training and updating); resuscitation training forms part of this. A CV is received for each candidate in order to verify skills and experience based on previous employment history. Once an agency worker is accepted by the Trust they receive training in our clinical systems, including the electronic health record system (PPM+); Symphony (the ED health record system); e-Obs (electronic observations) and Emeds (electronic prescribing/medicines management system). All agency nurses complete a supernumerary shift where they are buddied with a Trust member of staff and local induction is completed.

In this case the nurse involved in caring for the patient on 12th December 2021 was a substantive Trust employee. For these staff their substantive skill set holds true, as does their mandatory and priority training requirements. Currently there are no additional checks on completion of mandatory and priority training or DBS when substantive staff apply for the staff bank. This is because compliance with all mandatory and priority training elements is a requirement of their substantive position and is subject to regular reporting and review. As highlighted in response (2) above, the bank nurse in question was up to date with all her training requirements including resuscitation training.

Following the patient's death, and during the investigation into the care provided before it, the Trust identified deficiencies in the training provided for bank and agency staff about the crash call process used by the ED teams and action has been taken to address these.

Checks are now undertaken by the nurse in charge at the start of every shift to identify new starters. In addition, a local induction checklist is completed during the individual's first shift in the department. This completed checklist is signed by both the member of staff and the nurse in charge to provide documentary evidence that the process has been completed. This provides assurance that all temporary staff have been orientated to the department, have received explanations in regard to resuscitation procedures and the location of essential items of equipment including call bells, crash trollies, fire exits. It also confirms they have

an understanding of the procedures for reporting incidents and evacuating the department. During Matron assurance walk rounds, the nurse in charge undertakes spot checks to ensure that temporary staff meet departmental requirements and to identify any gaps in their knowledge that may need addressing.

(7) The investigation into the care provided to this patient was not a Serious Incident Investigation (level 3) within the terms of NHSE's Serious Incident Framework. Within the Trust there is a grading process to decide which incidents will be fully investigated. There are three main considerations when making this decision:
    - The level of severity of harm to the patient/carer/relative or staff member.
    - The likelihood of the event recurring.
    - The potential for learning

To help staff determine the level of investigation to be conducted a risk matrix is used. This provides a grading based on the consequence and likelihood of recurrence. Incidents are initially reviewed locally (within the Clinical Service Unit - CSU). If an incident is believed to fall within the definition of a Serious Incident, it is escalated to the corporate Risk Management team in accordance with the Trust's Procedure for the Reporting and Management of Serious Incidents (SIs). The incident is then considered by the Chief Medical Officer and Chief Nurse to determine whether it should be declared as a Serious Incident; if it is, an investigator independent of the CSU is appointed to lead the investigation.

In accordance with the Trust's Investigation Procedure, the incident report relating to Mr Heffron was discussed with the senior nursing team in the CSU and one of the ED Consultants who is the lead for risk related matters in the department. At this time the incident was scored at 5 (likelihood of occurrence rare; consequence catastrophic). During the discussions it was clear that at that stage the length of the delay between Mr Heffron being found in cardiac arrest and resuscitation starting was uncertain. It was agreed that if the delay was found to be significant then the incident would need to be escalated as a potential serious incident. If the delay was found to be of short duration, then the incident could be investigated locally. From initial discussions with staff involved a senior member of the nursing team was able to establish that there had been no meaningful delay and that the incident would be investigated locally.

For incidents with a risk score of 1-6 there is no requirement for staff to complete a formal investigation template. The Trust's Investigations Procedure explains that reviews may involve the multi-disciplinary team exploring ways to minimise a recurrence, or a review of the care plan. The procedure includes a contributory factors checklist and advises staff that this may provide a useful prompt for the review. Staff are required to document the outcome of the review on the investigation tab of the Datix incident form, along with details of any further action planned. The department/service should take the responsibility to identify learning points or safety improvement measures which are within the department's control and the line manager should ensure that any issues which are out of their control are communicated to the General Manager (or equivalent) for consideration/action. Lessons learned must be clearly documented.

Although the incident relating to Mr Heffron had been risk scored at 5, the team decided that a more formal investigation would be appropriate and agreed that a level 1 investigation would be undertaken, (usually undertaken for incidents scoring between 8-12), and this would be led by the nursing sister on duty at the time. The Trust's Investigations Procedure states that level 1 investigations should usually be carried out by the ward/departmental manager or clinical lead. It further explains that the investigation and analysis should be carried out by a suitably trained person (i.e. staff who have completed root cause analysis training) and an attempt should be made to establish a root cause.

At the inquest the senior sister confirmed she had completed lead investigator training, albeit several years prior to undertaking the investigation into the incident relating to Mr Heffron. Historically, investigation training has been provided as a one-off course as in the normal course of events staff start to utilise the skills they have acquired quite quickly after attending their training.

A review of the Trust's incident reporting system shows that the senior sister had reviewed 1060 incidents in her role in ED and as senior sister on one of the Acute Medicine wards. From these incidents she had led on 16 investigations. It is true to say that with the exception of one incident, all of these were related to in-patient falls; healthcare associated infections and hospital acquired pressure ulcers. These incident types have their own root cause analysis templates which look very different to the level 1 investigation report. The senior sister had completed one level 1 report previously. The investigation she undertook into the incident relating to Mr Heffron was overseen by one of the ED Matrons and therefore this was not conducted in isolation. It is accepted that ideally the investigation should have been undertaken by a member of staff who had not been on shift when the incident occurred, but the Trust's Investigations Procedure does not specifically require this as investigations are not undertaken in isolation of other members of the team. Only serious incidents are investigated by someone completely independent of the CSU.

In relation to your observations regarding the chronology of events it is noted that the incident summary in the investigation report does contain an outline chronology of events. It is acknowledged that it would have been helpful if this had contained more detail in regard to the time of the doctor's attendance and if the report had been supported by notes of discussions with relevant staff. The Trust's Investigation Procedure includes a range of tools and templates to assist staff when conducting investigations and whilst use of these is actively encouraged, it is not mandated. In response to the specific concerns raised about the investigation of this incident, the Trust has provided the ED senior nursing team with a memory capture tool to promote prompt and consistent recording of staff involvement in incidents and to formalise the evidence gathering stage of the investigation.

You will be aware from previous discussions that the Trust has been a pilot site for the new Patient Safety Incident Response Framework (PSIRF) which will replace the current Serious Incident Framework. It represents a significant shift in the way the NHS responds to patient safety incidents. The PSIRF promotes a range of system-based approaches for learning from patient safety incidents and national tools and guides have been produced to support this.

As a pilot site the Trust has had the opportunity to trial the new approaches and better understand the training requirements that will need to be delivered. All Trust staff charged with undertaking reviews under the new framework will receive training in how to conduct and record them. Support and advice, and regular updating sessions, will also be provided. The Urgent Care CSU has planned some bespoke sessions for their senior staff with the Trust's Risk Management team to complete training in relation to the new investigation documentation. This will help ensure that learning from incidents is maximised and documentation is completed to a high standard.

Your comments about the absence of any context regarding workload and staffing levels on the day of the incident are noted. The purpose of the investigation was specifically in relation to establishing whether there was a significant delay in commencement of CPR after the patient was found unresponsive; whether he had been receiving an appropriate level of monitoring at the time he was found unresponsive and whether any additional cardiac monitoring should have been in place prior to the patient's arrest. The timeline of events in the investigation report showed that the patient was reviewed at regular intervals, albeit that some of the intervals were longer than the agreed target times, and that he had the appropriate investigations. As highlighted in point 3 above, over the last two years the EDs have experienced an unprecedented demand in terms of attendances; patients requiring admission and an increase in the acuity of patients requiring treatment. The actions detailed are designed to help address these issues.

(8) From the response provided in point 6 above, I hope that you will be reassured that appropriate audit arrangements are now in place in the Trust to check bank and agency staff's familiarity with essential procedures in the ED, and to ensure that they have the knowledge base and confidence to follow them as required.

(9) As detailed in our response to point 6 above, the Trust's contractual arrangements with agencies supplying nursing staff requires that the staff supplied have full and current nursing qualifications, together with up-to-date training to specified standards in areas relevant to the work they will be undertaking. Bank staff supplied to the ED by the Trust's internal deployment team must meet the same standards. All nurses working in the ED are required to undergo departmental induction, whether they are substantive members of staff, agency, or bank nurses.

Thank you for bringing these issues to my attention. I hope that this response provides confidence that the Trust has considered and addressed them appropriately.

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

Yours sincerely

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