East London
NHS Foundation Trust

Office of the Interim Chief Medical Officer
Trust Headquarters
5th Floor
9 Alie Street
London E1 8DE

[redacted]

08.11.22

PRIVATE AND CONFIDENTIAL

Acting Senior Coroner G Irvine
[redacted]

Dear Sir

Regulation 28 Report – Ms Delina Etienne

I am writing on behalf of East London NHS Foundation Trust to provide a formal response to the Regulation 28 Report that you issued on 12 September 2022 following the inquest touching the death of Ms Delina Etienne.

Your conclusion at the inquest was that Ms Etienne died of natural causes, and your Regulation 28 report notes that the actions of the senior nurse were not found to have caused or contributed to her death.

The Trust expresses its sincere condolences to Ms Etienne's family. The Trust's internal investigation found that various things did not happen as they should have done with Ms Etienne's care, and although they did not ultimately affect the tragic outcome, the Trust is determined to address these issues so they do not re-occur. Your Regulation 28 Report is a helpful tool to focus the Trust's efforts, and has been carefully considered at a senior level.

Your Regulation 28 Report raised five matters of concern, and I have set out below details of the actions which the Trust has taken (or will take) in relation to them. Please note that actions which have not yet been completed are anticipated to have a timescale of 6-12 months.

1) Response to cardiac arrest

Physical health simulations training is facilitated across the ELFT Trust inpatient units. Simulation training sessions are being undertaken at least monthly in all units. Emergency simulations have also taken place on Cazaubon Ward on the following dates and are ongoing.

- 11.08.21
- 08.10.21
- 21.04.22
- 14.10.22

From 10.10.22 a weekly ward managers meeting now has an agenda item to plan a simulation exercise for that week within the East Ham Care Centre unit.

The Trust identified particular concerns about two members of staff involved in the incident. The two members of staff have subsequently attended further Immediate Life Support Training. The training highlights the action to be taken by a staff member who finds a patient/person in a physical health emergency including a person with no pulse or other life signs. It teaches staff how to start compressions, get help, apply, and use an automated defibrillation machine (AED), check the paper copy of any do not attempt resuscitation prescription, call for an emergency ambulance and continuing resuscitation until paramedics take over and make any decision about discontinuing this attempt. Both nurses were placed on restricted duties until the Director of Nursing received confirmation that they had appropriately reflected on their actions, showed sufficient insight and understood the consequences of their actions as well as evidenced learning from the intermediate life support training.

The existing Trust policy on 'Resuscitation' has been discussed at Cazaubon Ward staff away days organised by the Cazaubon ward Matron and the following topics were discussed:

- May 2021 –Managing Sudden death on the ward
- 25.08.2021 –Sudden Unexpected Incidents
- 15.12.2021- Managing Medical Emergencies

Monthly audits of the ward in relation to resuscitation status record-keeping started in May 2022 and are ongoing.

All Cazaubon Ward staff have been advised on the location of the DNACPR forms red folder, and that this is the first point of reference in a medical emergency.

A DNACPR electronic alert is now available within the RiO medical records as a secondary aid.

CPR status is now a formal part of the handover for each nursing shift on Cazuabon Ward.

The author of the Trust policy for resuscitation will amend the policy to emphasise the correct procedure for recording in RiO and communicating CPR, and the use of a defibrillator at the earliest opportunity.

The Trust's DNACPR forms will also be reviewed to see if improvements are required.

2) Escalation of raised blood pressure

NEWS 2-update training on blood pressure has been undertaken by 62 staff, and NEWS 2 scores template and recording within the RiO medical records has now been revised.

The electronic recording system for NEWS 2 now has automatic alerts for all physical health observations recorded which are outside expected limits. This highlights any concern and advises on action to be taken by the person entering the readings.

A training template was created and reviewed with each Cazaubon Ward staff member in May 2022.

Further training was undertaken with all staff on Cazaubon Ward concerning elevated blood pressures on an away day on 23.06.2022. As a result, staff should ensure that they recheck the blood pressure with another machine and also undertake a manual blood pressure if indicated.

The relevant NICE Guideline (NG 136) is visible on the ward.

Monthly audits of the ward in relation to management of blood pressure started in May 2022 and are ongoing.

3) Venous Thromboembolism (VTE) assessment

All patients have a VTE assessment undertaken on admission to Cazaubon Ward. This was audited on 03.11.22 and will continue to be audited weekly. A request has been made to have the Trust's automated reporting system updated to facilitate the ability to run a report on each wards VTE screening assessments.

The author of the Trust policy for physical healthcare will amend the policy to emphasise that all patients need to have a VTE risk screening assessment undertaken on admission and the correct procedure for recording this in RiO.

The nurses' physical health assessment is being amended to include a VTE screening assessment which would require a medical assessment to be completed if a risk was identified. Once this has been amended Cazaubon wards nursing staff will complete a screen for each patient as part of the wards weekly audit programme.

4) Medical review of chest pain

Training was undertaken regarding the correct escalation of a patient with chest pain at the Cazaubon Ward away day on 23.06.2022. A separate training programme was completed for all staff on an individual basis. This covered the requirement for a staff member to stay with the patient and mange chest pain like any other medical emergency, calling for the immediate attendance of a doctor or emergency services, continual monitoring of vital signs, the use of oxygen and preparing information for

paramedics. This training will become part of the year updated competency training for staff.

There is access to geriatrician advice weekly for physical health concerns related to any of the patients on Cazaubon.

5) Disclosure of DNACPR error

The Trust agrees that the member of staff should have clearly disclosed the error. In particular, the Trust acknowledges that it must have been distressing to the family to find out about the error via the Serious Incident Report rather than immediately after the incident. The Trust has however established that the relevant member of staff did flag the error to their manager in the immediate aftermath of the incident, and is satisfied that that there was no deliberate intention to conceal any error. As well as reporting the incident to their manager, the member of staff also completed a Datix report, knowing it would trigger an internal investigation which would then examine the detailed circumstances of the incident. The Trust is satisfied that the member of staff has adequately reflected on their practice and would communicate more clearly in the future. This reflection was carried out with one of the Trust's Directors of Nursing as part of individual reflection exercises with all the staff involved in the reporting process of this incident.

There are now more senior staff rota'd on Cazuabon Ward who can provide a higher level of support with the reporting of future incidents.

Two away days for duty senior nurses at the East Ham Care Centre have taken place, both of these covered learning from incidents including all the learning from this serious incident, in particular the disclosure of issues at the earliest opportunity through all reporting processes.

Three away days have been booked for the rest of the nursing teams for the unit and will include the same dissemination of learning.

The process of completing 48 hour reports in the directorate has been changed to ensure they are vetted by a lead nurse before submission.

Further to the specific Ward-based initiatives, learning has (and will continue to be) disseminated through the Trust-wide Patient Safety Forum. This is in addition to actions which will already have an impact across the Trust (for example in relation to Trust-wide policies and the Trust's electronic records system, RiO).

I hope that this provides you with the necessary reassurance that the Trust has taken appropriate action following Ms Etienne's very sad death.

Yours sincerely

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Interim Chief Medical Officer