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Date: November 11, 2022

Private & Confidential
Mr Graeme Irvine
Senior Coroner
Walthamstow Coroners Court
The Adult College of Barking &
Dagenham
127 Ripple Rd
Barking
IG11 7PB

Dear Mr Irvine

RE: Regulation 28 Prevention of Future Deaths Report

I write in response to your Regulation 28 Report to Prevent Future Deaths, dated 30th September 2022 touching on the death of Shahan Abu Aman.

I can assure you that, prior to the receipt of your report, the Trust recognised the severity of the concerns raised by this sad case and has undertaken a large amount of work to ensure that the chance of recurrence is reduced to a minimum. We believe that our response will hopefully provide a level of reassurance to address the matters of concern outlined in your report.

While acknowledging the seriousness of the highlighted concerns, it is important to note that this incident occurred on the background of a department that saw 150,487 patients; of which 37,146 were children in the year 2021. We do not believe that there is an inherent systemic process failure; however, we have introduced controls as outlined below which are designed to minimise the risk of recurrence of this tragic outcome.

This Paediatric Emergency Department provides 24 hour per day cover and serves a diverse community. It is staffed by medical and nursing staff of various grades, and it has systems in place that ensure safe triage and disposition. To support the final disposition of patients we have an in-patient ward, a paediatric assessment unit, our co located GP run urgent treatment centre, as well as a resuscitation room.

Matters of Concern.

A series of miscommunications between, nursing staff, junior and consultant paediatric medical staff resulted in concerns regarding Aman not being properly considered prior to discharge. Staff relied on assumptions that others understood the factors affecting Aman and had a plan to resolve them, this was not the case. Had effective communication occurred it was unlikely than Aman would have been discharged.

In this particular case, which we believe to be an isolated incident, there was a communication failure as identified as a matter of concern . It is extremely difficult with any communication failures to pinpoint an exact cause. However, despite this being said, the department did recognise the failure of this important element that did translate into the erroneous discharge decision.

With any tool that is used to quantify risk, such as an early warning score, there is always the possibility that it will never be 100% sensitive. The department has recognised that in patients presenting with gastroenteritis, despite them being critically unwell, the early warning score system may not recognise this and lends itself to aligning itself with a false sense of reassurance. In this case the individuals concerned recognised the patient was unwell but there was a communication failure where the weight of their concern was not able to be translated and transmitted for everyone to be aware.

The Paediatric Emergency Department has now implemented and is using a detailed 2 hourly SITREP (Situational Report). The SITREP aims to capture this exact concern from members of staff who are worried about a patient who, despite the psychological parameters being abnormal, the early warning score does not identify this concern.

The Paediatric SITREP report addresses this element of concern as evidenced below.

MRN for patients with PEWS ≤6 AND nursing or medical concerns	MRN	Current PEWS	What is the concern?	Escalated to senior?	Plan?
Patients triggering PEWS ≤6 BUT nursing/medical concerns should be recorded here and escalation plan noted.	0				

The above tool is an objective measure that provides a trigger for staff to identify, document and escalate the concern. The tool is run on a 2 hourly basis every day.

The severity of this case was also personally discussed and fed back by the Clinical Director of the Emergency Department and by the Consultant in Paediatric Emergency Department at various forums. Within these forums the importance of communication was strenuously emphasised.

The theme of communication failures was furthermore specifically discussed with all the senior paediatric nursing staff by the Clinical Director on 15th July 2022 with an attendance register which has already been evidenced. We would like to emphasise that the nursing staff who were involved in this case, were also present and shared their involvement and learning with this case.

Over and above what has been mentioned, the theme of communication failure was not just aimed at the Paediatric Nursing team but is one that the Clinical Director himself personally emphasises; and has done so for at least 7 years at the Junior doctor's induction programme. The department feels confident that its messaging regarding the risks of communication failure are constantly reinforced.

Communication failures alone were recognised as not being the sole contributor as clinical knowledge regarding diarrhoea and vomiting in children and the risks of its dangers being under-appreciated were

also acknowledged. With this in mind, the evidence bundle which has already been provided, demonstrates all the teaching and educational efforts that we have put in place and continue to provide; highlighting the importance of this case. Within these teaching modalities, although not explicitly mentioned, the emphasis on communicating concerns remains a rolling theme.

This case and its investigation have also fed into the Trust's robust clinical governance process that emphasises learning from incidents and a just culture. This as well as all serious incident investigations conclude with actions to ensure final reports are shared with relevant clinical staff for their reflective learning. Learning summaries are also completed for all investigations and this is shared across all hospitals within the Trust for learning. These steps have all taken place with respect to this case.

Serious incidents relating to specific themes are also discussed for learning as appropriate through relevant governance arrangements. For example, incidents of failure to rescue are considered at the hospital deteriorating patient improvement group, as well as other groups such as pressure ulcer incidents reviewed at the hospital pressure ulcer improvement steering group and falls related incidents at the hospital falls improvement group.

Specific sharing of lessons learned from incidents, as was in this case, also occur through speciality governance meetings, through to divisional governance meetings and the hospital quality and safety board.

Furthermore, the implementation of actions resulting from "recommendations for action" following serious incident investigations have oversight through the divisional governance boards, and the hospital quality performance reviews. In this particular case, the actions have been completed and evidenced.

The doctor who authorised discharge did not satisfy himself of the most recent set of clinical observations and associated Paediatric Early Warning Sign (PEWS) score prior to discharge.

This is a theme that was recognised before the inquest. In response, processes were put in place whereby the last set of observations and blood results over which a clinician makes an entry into the records, are auto-populated so that the clinician can be sighted on these. In this particular case the early warning score identified only 1 abnormal parameter which, according to National Guidance, does not merit repeated frequent observations. However, as mentioned above the department fully recognises that no system can be 100% sensitive and has put in a large amount of effort to ensure that the messaging/learning is shared that children presenting with gastroenteritis, despite low early warning scores, can be critically unwell. This educational programme has already been demonstrated in the evidence provided to the court.

The clinician in this particular case recognised that he did not satisfy himself with the most recent set of clinical observations that were undertaken but not translated to him. The clinician has undertaken a large amount of self-reflection where he has demonstrated insightfulness with respect to his involvement in the case and demonstrated how he has educated himself; thus, minimising the likelihood of a reoccurrence again.

The Paediatric Emergency Department was particularly busy that evening, with a combination of high patient numbers and severe acuity of symptoms. The accounts provided by Trust witnesses was that resulted in a pressurised environment and that this was a situation that occurred with an increasing level of frequency over the last two years.

The Paediatric Emergency Department on a 24 hour basis is supported by consultants and registrars who are at the level of ST4 and above. In this particular case the Emergency Department doctor was one who had already taken a period of training in paediatrics and was one who was working at the level of ST4 i.e. that of a senior decision maker. This case unfortunately highlights the reality that clinical judgements can be difficult even in relatively experienced and expert hands.

On this particular day the department was extremely busy and it is not always possible, as is the case in all Emergency Department, that every shift would be 100% fully staffed with no need for locums or the movement of staff from one area to another.

The organisation has recognised a number of areas of pressure in the emergency departments and is in the process of working through process pathway redesign so that we can potentially reduce the pressurised working environment and reduce levels of risk.

Outside the Emergency Department the Trust has plans to work alongside North East London to support paediatric flow, from the Emergency Department. This includes, but is not limited to, exploring ambulatory step down from the paediatric ward, increased use of paediatric clinical decision unit to work into the community to support early discharge. In addition to working alongside the complex discharge team, we are exploring additional roles to support children on the ward who find themselves stranded to an array of complex conditions. This is all monitored through the divisions, support and assurance meetings up to and including the Executive boards.

Thank you for bringing your concerns to my attention. I am very happy to discuss or clarify any of the above points.

Yours sincerely

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Chief Medical Officer