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NHS Trust

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Private and Confidential
HM Coroner Mary Hassell
Senior Coroner
Inner North London
St. Pancras Coroner's Court
Camley Street
London N1C 4PP

28 December 2022

Dear Senior Coroner Hassell

Re: Regulation 28 Prevention of Future Deaths (PFD)

I am writing to respond to the Regulation 28 Prevention of Future Deaths 9PFD) report for Roy Travers. This response is written on behalf of Whittington Health. Following the inquest, you raised the following matters for concern and the actions we have taken in response to these concerns are as follows:

Matter of concern 1- *Melaena was noted at 8.45am on 4 June 2022, but it was another 12 hours before medical staff reviewed Mr Travers. There appears to have been a failure to escalate. A doctor was asked to see him earlier that day, but about a different issue.*

The Ward manager [redacted] has given feedback to the nurse who did not escalate melaena. The nurse has booked to attend a course in January 2023 which includes how to recognise and manage the deteriorating patient. This course will re-enforce knowledge, improve competence, encourage better communication, and enhance team working. This course is run by the Critical Care Outreach Team.

Further training for ward nurses is being put in place to cover the recognition and escalation of gastrointestinal bleeding is being organised by the Associate Director of Nursing and will be led by the endoscopy nursing team.

Matter of concern 2 - *As identified at the Whittington 72-hour review, the reviewing doctor who later considered Mr Travers' condition in the light of the melaena, then failed to withhold his anti-coagulation therapy, apixaban. It is unclear from the review whether that doctor has since been given direct feedback and a learning opportunity.*

Direct feedback and learning were given to the reviewing doctor by their Educational Supervisor, as confirmed in an email on 9 June 2022.

The following aspects were covered:

1. Assessment of gastrointestinal bleeding using a systematic approach A-E to assess an unwell patient
2. Stopping anticoagulation/reversal
3. Repeat blood tests and handover of these patients.
4. Documentation of the Glasgow Coma Scale.

Matter of concern 3 - *The 72-hour review identified the need to discuss Mr Travers' care at the relevant morbidity and mortality meeting. It is unclear from the review whether that discussion has taken place.*

The discussion of this case took place on 21 July 2022 at an Acute Medicine team mortality and morbidity meeting. This meeting was chaired by Dr. [redacted], the mortality lead for Acute Medicine. The case was presented and led by Dr [redacted], Associate Medical Director for Quality Improvement and Clinical Effectiveness. The meeting was attended by other Consultants in Acute medicine, junior doctors, and nurses. The above is confirmed in an email on 2 December 2022 sent to the Associate Medical Director for Patient Safety and Learning from Death.

Matter of concern 4 - *Mr Travers' sons told me at inquest that, when Mr Travers' was nursed on Mary Seacole Ward, they felt that staff regarded this confused, elderly man as a nuisance. That is clearly unacceptable. In addition, Mr Travers' family worried that this view of him clouded the judgement of those looking after him.*

[redacted] Ward Manager of Mary Seacole, offers her sincere condolences to Mr Travers' family. Ms Bakari advises Mr Travers had an electronic alert to notify staff of his additional care needs due to his dementia. Due to his risk of dehydration [redacted] herself supported to insert a new intravenous cannula. A 1:1 was also implemented to support his safety (prevention of falls risks) whilst he was being nursed in a side room. There is clear documentation that nursing staff were supporting him with taking oral fluids and offering food and assisted him with his personal hygiene needs. Staff regularly care for patients with confusion but [redacted] felt Mr Travers needs while confused were manageable on the ward and appropriate to the skills of the staff.

[redacted] offers apologies to the family for the perception of the care.

Matter of concern 5 - *As you will be aware, an ancillary function of every inquest is to attempt to learn lessons from the death, the driver behind prevention of future deaths reports. However, it is incumbent upon every hospital trust to consider the deaths of those within its care long before the matter comes to inquest, and to attempt to learn from these if possible.*

Whittington Health conducted a 72-hour review of Mr Travers' care on 17 June 2022. This was disclosed to my coroner's officer late on the afternoon of Friday, 4 November, in preparation for an inquest listed for 10am on Monday, 7 November.

This meant that Mr Travers' family and I received the 72-hour review on the morning of inquest. This had several consequences.

- *It placed family members in an unfair position in terms of their preparation for inquest.*
- *It did not comply with the duty to co-operate with HM Coroner, not simply when asked but also by volunteering all relevant information.*
- *It denied HMC the ability to call to inquest any witnesses the need for whom only became apparent from the review.*
- *And it did not inspire confidence that Whittington Health took its own review seriously and tried to learn from it. Even the Whittington consultant giving oral evidence at inquest only saw the review on the morning of inquest, and then purely as a result of being provided it by my coroner's officer.*

Mortality review meetings are led by the department mortality leads. There is evidence to support that these meetings are taking place, including provision of timely mortality reviews. These meetings provide opportunities to capture and share the learning from death. This case was discussed at a Mortality Meeting on 21 July 2022.The Associate Medical Director for Patient Safety and Learning from deaths collates the learning and reports this to the Trust board level Quality Assurance Meeting on a quarterly basis. This has continued throughout the COVID-19 pandemic.

Learning from deaths have been shared in Grand rounds, highlighted in the Trust wide Patient Safety newsletter and the monthly Patient Safety Forum.

The coroner has commented that her team had to share the 72-hour report with the consultant giving evidence. The legal department sent the 72-hour report to Dr [redacted] on 4 December 2022 by email – in the week prior to the inquest - but we fully accept that this should have been a much more timely process.

In preparing this response the Associate Medical Director for Patient Safety and Learning from Death has shared the information with Head of Nursing, Clinical teams, Patient Safety Group and the Quality Governance Committee.

Yours sincerely

[redacted]

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