Oxford University Hospitals
NHS Foundation Trust

The John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

[redacted]

6 July 2023

PRIVATE AND CONFIDENTIAL

Mr Tom Osborne
HM Senior Coroner for Milton Keynes

[redacted]

Dear Mr Osborne

Inquest into the death of David Wood

Following the tragic death of Mr David Wood, and subsequent inquest on 6 December 2022, I am writing on behalf of Oxford University Hospitals NHS Foundation Trust (OUH) to provide a response to your Regulation 28 Report to Prevent Deaths dated 7 June 2023.

The inquest referral from the Milton Keynes Coroner's Office dated 28 October 2022 indicated that you did not require any formal evidential reports from OUH clinical staff, but you asked that OUH provide a copy of the Structured Judgment Review once completed. As such you did not hear any evidence from OUH clinical staff at the inquest hearing on 6 December 2022.

A copy of the Record of Inquest was sent to OUH Legal Services after inquest hearing, but nothing further had been heard from your office until 7 June 2023 when the Regulation 28 Report was sent by email to OUH Legal Services ([redacted]).

At section 5 of the Regulation 28 Report to Prevent Future Deaths you have set out your concerns:

"*Following the death of Mr. Wood a review was conducted by the trust and the review recognised that it would have been helpful if the symptoms of delirium had been highlighted to the GP and that it would have been useful if there had been a discussion with* [redacted] *to educate her as to the possibility of delirium, and to help plan his discharge from hospital and inform her when she should seek further medical assistance. The protocols for discharge following heart surgery should be reviewed in order to prevent similar deaths".*

The OUH Structured Judgment Review dated 17 August 2022 was written as part of the OUH's Mortality Review Process and disclosed to your Officer prior to the inquest

hearing on 6 December 2022. Based on the SJR plus internal management review processes, the Directorate identified four key learning points:

1. Including a section in the Pre-Operative Assessment on previous mental health and substance use in the past medical history section, would represent best practice in highlighting patients with significant psychiatric histories so that appropriate care could be instituted during and after the admission.

   The POA clerking proforma has been amended accordingly and patients are also given a leaflet explaining the small chance of post-operative delirium, and that it is usually transient.

2. If post-operative delirium occurs, considering involving an appropriate family member in discharge discussions (with the patient's consent), to alert them to what to expect in the process of recovery and when to seek further medical assistance after discharge.

   Since the incident, this has been addressed via a full-time discharge coordinator for the heart centre adopting more of an MDT approach. The nursing team have also been educated about the free NHS talking therapies service plus the British Heart Foundation resources online support groups and information.

3. Amendment to consent-form stickers used to list frequent or clinically significant complications after cardiac surgery, which previously did not include delirium.

   This has been addressed.

4. The liaison process for seeking advice and/or direct clinical input from Psychological Medicine for in-patients should be clarified.

   The Psychological Medicine Team have indicated that initial contact for both types of referral to their service is via the rostered Consultant-of-the Week, either via phone or bleep.

The Divisional Director of MRC Division, which includes Cardiac Surgery, has provided assurance to me that the actions to implement the four learning points have been completed.

Yours sincerely

[redacted]

[redacted]

Chief Executive Officer