Barts Health
NHS Trust

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Group Chief Medical Officer
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Date: 14th September 2023

Private & Confidential
East London Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Dear HM Coroner,

Thank you for your letter dated 11th July 2023 following the inquest of Mr John James detailing concerns arising from the evidence presented and inviting the Trust to consider the implementation of changes to reduce the risk of future harm or death.

The Prevention of Future Death report has been reviewed at the Whipps Cross Hospital Board and Divisional Board to agree actions that will be adopted across the Barts Health group.

Your concerns

1. The refusal of anti-coagulation medication was not brought to the attention of medical staff. The administration of anti-coagulation medication to patients like Mr James, is vital for reducing the risk of a venous thrombo-embolism, a potentially life-threatening condition. There is no electronic prompt/alert to highlight to the medical team when prescribed anticoagulation medication is not administered.
   In cases where a patient declines critical medication e.g., VTE prophylaxis, anti-seizure medication, documentation must be very clear that the patient has capacity to understand the risks associated with this decision.

   Learning from this serious incident investigation has been shared across the organisation as part of the standard post investigation process to share learning across the group.

2. The Trust's internal investigator recognised that a fail-safe should be put in place within the electronic records, to ensure escalation to the medical team where doses of prescribed anti-coagulation are not administered. Such a measure could prevent similar deaths from occurring. It was considered that this measure could assist in preventing future deaths not just locally, but at a wider level.

   Our response:
   The electronic prescribing and medicines administration system (ePMA) currently has functionality (all of which is accessible via Millennium®) to reduce harm associated with missed or late medication administration. This includes visual aids in the form of a red tile if a dose is delayed by more than 2 hours. This visual flag is available to all users. Millenium training will be updated to reflect learning from this case to ensure that multi-professional teams know how to use the flag system to ensure critical medications are not omitted.

   Minimising medication dose omissions is a Trust medicines safety improvement priority supported by the trust Medicines Safety Committee. A medicines safety dashboard is being developed and will provide data on dose omission over a given period. The information will be used to track each ward's performance and to support quality improvement programmes across the Trust on dose omission.

Actions in relation to this letter and evidence of completion will be presented at the Whipps Cross Quality and Safety Committee and by exception to the Trust Quality Assurance Committee.
The Trust deeply regrets that the serious incident investigation report and associated action plan did not provide HM Coroner and the patient's family with sufficient assurance around the actions implemented. Arrangements will be made to share this letter with the patient's family and an offer will be extended to them to meet with senior clinicians to discuss any questions, concerns or additional learning and improvement that the Trust should implement in light of the death Mr John James. If you have any further comments or questions, please do not hesitate to contact me.

Yours sincerely

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[redacted]
Group Chief Medical Officer
Barts Health NHS Trust