DEPUTY CHIEF EXECUTIVE'S OFFICE

[redacted]

22 December 2023

Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ

[redacted]

For the attention of Ms Emma Brown, HM Area Coroner for Birmingham and Solihull

Dear Madam

Report issued under Regulation 28 of the Coroners (Investigations) Regulations 2013 to St Andrew's Healthcare

1. Introduction

1.1. I write in response to the above matter and your report dated 1 November 2023. I have been asked by the Charity's Chief Executive, [redacted], to provide you with a response on behalf of the Charity. I have considered your report, spoken with colleagues and directed further action. For the purposes of this response I will refer to St Andrew's as "the Charity".

1.2. I would like to reassure you that the Charity is taking the issue of compliance with training and knowledge of policies extremely seriously. It is a metric that is considered in regular management meetings and an issue that all line managers prompt their colleagues on to ensure training is kept up to date.

1.3. The Charity structure is designed so that there are lines of reporting and assurance between the wards, divisions, Operational Delivery Committee, Executive Team, the Board of Directors and the Court of Governors. The structure allows for oversight and assurance being maintained for governance and quality activities, as well as for operational and financial performance via the various groups and committees at various levels throughout the Charity. I share your concern that these processes did not pick up the issues with policy compliance in the care Mr Mishabi received in early 2023.

2. Investigations Undertaken and Explanation

2.1. In preparing this response, enquires have been made with the Clinical Director and Associate Director of Nursing at the Birmingham Hospital.

2.2. We have spoken with [redacted] about his knowledge of the Charity's Pressure Ulcer Prevention and Management Policy and we are clear that he is aware of this policy and he has explained that he was very nervous when he was giving evidence at the inquest. I also understand that during [redacted] evidence he did accurately describe aspects of the policy despite him forgetting that the policy existed.

2.3. We also understand that in early 2023 when Mr Mishabi was unwell and there were issues with his pressure ulcer management, [redacted] was on leave and not on the ward, so his knowledge (or any actual or perceived lack thereof) of the policy will not have been a contributory factor in the pressure ulcer care Mr Mishabi received in March 2023.

2.4. We have also enquired into the training provided to the team on Lifford ward and in addition to the e-learning, of which you have received a copy, the Charity's Head of Physical Healthcare arranged in-person bespoke training on pressure ulcer management which was attended by members of the Lifford ward team.

2.5. It also needs to be acknowledged that on Mr Mishabi's return to St Andrew's on 3 April 2023 the pressure ulcer care Mr Mishabi received was of a higher quality than on and around 15 March 2023. The principle reason for this appears to be due to better communication and ownership by the physical healthcare team of the issue of Mr Mishabi's pressure ulcers.

2.6. [redacted], Clinical Director at the Charity's Birmingham Hospital, has also commented that he personally attended upon Mr Mishabi on 3 April 2023 following his return from the Queen Elizabeth Hospital on the evening of 2 April 2023. [redacted] clinical opinion is that it the Prevention of Future Deaths Report is incorrect to state that *"Following discharge [from QEH] the ulcers proved difficult to manage and deteriorated."* [redacted] view, which is supported by the RiO notes that you had access to, is that Mr Mishabi's pressure ulcers had not been appropriately treated at QEH and he had been prematurely discharged. We can provide you with a further copy of these notes if it would be of assistance. The discharge summary provided by QEH made no mention of any pressure ulcers, no nursing discharge summary was provided nor had any pressure ulcer leaflets been provided to the Charity as QEH have claimed. It is also noted that QEH did not invite the Charity to participate in its serious incident investigation, which may have been of assistance given there have been issues with quality of the discharge summaries received by the Charity in relation to other patients. This is also supported by the Charity's Mortality Surveillance Review, which was provided to you, which concluded:

> *"Mr Mishabi may have been prematurely discharged by colleagues at the QE on 2/04/23 as he was rapidly readmitted. Some liaison about how psych wards work and that the level of fitness required to be discharged to a psych ward being equivalent to that required to be managed in a domestic setting may be useful for QE colleagues going forwards."*

2.7. The Charity would highlight that whilst elements of the Charity's Pressure Ulcer Prevention and Management Policy were not followed in early 2023, Mr Mishabi did have a pressure ulcer prevention care plan in place as the team on Lifford ward were aware that he was at high risk of pressure ulcers. This included ensuring Mr Mishabi had access to an airflow bed, a pressure relieving cushion for use on his wheelchair, implementation of a turning

regime and regular observations to prompt him to keep moving from one position. Whilst there were deficiencies in the completion of Waterlow Pressure Scores and Skin bundles, this had no effect on the care Mr Mishabi had access to as all the available options to limit his risk of pressure ulcers were already in place. Mr Mishabi was also regularly reviewed by the Physical Healthcare Team and was swiftly and appropriately escalated to the QEH on both 18 March and 4 April 2023.

2.8. A significant change at the Birmingham hospital since Mr Mishabi's admission is that there is now a designated senior nursing leadership team in the form of an Associate Director of Nursing as well as two Quality Matrons in place who have better oversight of the governance structures designed to pick up issues such as missed Waterlow Pressure Scores. It appears that it is not a case that the clinical governance structures are inadequate – more that the implementation needed some refinement and support, which is now in place

2.9. Lastly, it should need to be acknowledged that whilst there were issues in early 2023 with the Charity's compliance with its Pressure Ulcer Prevention and Management Policy, there is a large body of evidence that overall the care Mr Mishabi received for his physical health was of a high standard. The team on Lifford ward worked extremely hard to manage Mr Mishabi's multiple physical health illnesses, namely diabetes mellitus, hypertension, end stage kidney failure and ischaemic heart disease at times in challenging circumstances, when Mr Mishabi's mental disorder meant that he was not willing to follow clinical advice that was in his best interests.

3. Actions Taken

3.1. The Charity is committed to learning from past incidents and has an ongoing commitment to improving care standards. Despite the concerns about the nature of Mr Mishabi's discharge from QEH, the Charity acknowledges that there are areas where improvements are needed based on the learning from the care provided to Mr Mishabi, an individual with complex mental and physical illnesses.

3.2. Since Mr Mishabi's death, a number of changes have already been implemented that have strengthened the physical healthcare provision and the governance arrangements at the Birmingham hospital. I would therefore highlight the following changes:

Change 1: **Structure of the Physical Healthcare Team**

The physical healthcare team now comprises three nurses and the Associate Specialist/Non-Consultant doctors, who operate under a clear escalation plan. This enlarged team is designed to ensure a comprehensive approach to both mental and physical health needs.

Change 2: **Improved Training for Ward Teams**

Ward-based teams receive extensive training and ward managers hold responsibility for daily observations, which include Waterlow Assessments, Skin Bundles and NEWS assessments.

There is now extensive training provided to ward-based teams in recognising signs and symptoms of physical health requirements.

Change 3: **Clearer Accountability and Responsibility for Physical Healthcare**
Since Mr Mishabi's death, a triumvirate leadership team consisting of substantive postholders in the roles of Clinical Director, an Associate Director of Nursing and a Director of Operations is now in place.

The Associate Director of Nursing has implemented robust procedures for monitoring physical healthcare, which has set physical healthcare KPIs as a priority KPI. The Associate Director of Nursing ensures that colleagues are held accountable for compliance.

The Associate Director of Nursing is a physical healthcare advanced practitioner and therefore has expertise and a professional interest in this issue. A well-defined governance structure supports a multidisciplinary decision-making process including Quality Matrons who are responsible for monitoring the quality of the care provided

Change 4: **Clear Escalation Plan and Daily Monitoring**
A well-defined escalation process in place to address any health needs promptly, with ward managers holding responsibility.

Regular observations, Waterlow and Skin bundles and NEWS2 assessments conducted daily during safety huddles or divisional huddles.

Change 5: **Incident Review**:
Acknowledgement of lapses in compliance with pressure ulcer prevention policies, with a commitment to continuous training and oversight.

Change 6: **Charity-wide Communication**
The Charity has already sent out a reminder to all staff about the importance of competing regular Waterlow Pressure Scores and complying with the Charity's policies.

3.3. In addition, the Charity is going to undertake the following additional actions:

Action 1: **Undertake an informal audit/dip test of the Daily Huddles**
The Associate Director of Nursing will be undertaking a random sample of daily huddles to ensure that issues with the Waterlow Pressure Scores and other physical healthcare tests are being considered at the daily huddles.

Action 2: **Training**
The Charity is going to ensure all staff on Lifford ward, which cares for the patients at highest risk of pressure sores in Birmingham, receive face to face training on pressure sores.

4. Summary

4.1. Having considered your report, we acknowledge that whilst the Charity still has significant concerns about the nature of Mr Mishabi's discharge from QEH, which are not addressed in the action plan provided to you, there are areas around the compliance with policies and the governance processes that can be improved upon.

4.2. The Charity's Birmingham hospital has benefited significantly by the strengthened local leadership team and is now a significantly different service from at the time of Mr Mishabi's death.

4.3. I hope the additional steps outlined in this letter will provide you with some reassurance that there is a reduced risk of future deaths following the actions that the Charity has and will take.

Yours faithfully

[redacted] **MB BS FRCPsych MBA FFMLM**
Deputy Chief Executive