University College London Hospitals
NHS Foundation Trust

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5th February 2024

HM Coroner Hassell
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Senior Coroner,

**Re: Sarah Chappell Prevention of Future Death report**

I write to provide you with a detailed response to the Regulation 28 report dated 7th December 2023, regarding the death of Sarah Chappell on 23rd June 2023. We have worked together across the organisation with the multi-professional teams involved in Ms Chappell's care, to provide a thorough response covering the six areas of concern raised in your report. We are committed to continuing to implement the learning and improvements identified. This includes a focused commitment to improving the care provided to patients with a learning disability. We have reviewed and strengthened our governance structures, with the chief nurse now chairing the safeguarding adults committee and the learning disability steering group. The learning disability steering group (a sub-group of the safeguarding adults committee) will seek assurance from clinical teams and divisional leads that the actions outlined in this response are met and will report via the adults safeguarding committee to the quality and safety committee (a sub-committee to Trust Board). This response will also be monitored through our patient safety committee. As part of this commitment to improving the quality of care for patients with a learning disability, we have also appointed a second learning disability nurse who has been in post since August 2023. Expanding this capacity has allowed us to both increase patient case management and deliver bespoke training and education for staff.

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| 1 | **This response is made on behalf of**<br>[redacted], Chief Nurse, University College London Hospitals NHS Foundation Trust |
| 2 | **Regulation 28 Report**<br>This response follows a report by Coroner ME Hassell on 7th December 2023 |

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| 3 | **Investigation and inquest**<br><br>On 4 July 2023 I commenced an investigation into the death of Sarah Chappell, aged 43 years. The investigation concluded at the end of the inquest earlier today. I made a determination as follows. Sarah Chappell died from the recognised long term complications of necessary medical treatment. However, in addition to these, during her last admission to hospital her care was suboptimal because the appropriate team did not take charge. Placement of her nasogastric tube was not managed appropriately over her final weeks. If it had been, she would have survived this episode. I recorded the medical cause of death as: 2 1a aspiration of gastric contents 1b adhesional small bowel obstruction 1c status post multiple complex surgeries flowing from an Arnold Chiari type II malformation with spina bifida & complicating hydrocephalus 2 metastatic adenocarcinoma of the rectum |
| 4 | **Circumstances of the death**<br><br>Sarah Chappell was transferred to University College London Hospital from the Princess Royal University Hospital in Orpington on 31 May 2023. She remained at UCLH until her death on 23 June 2023. |
| 5 | **Coroner's concerns**<br><br>The MATTERS OF CONCERN are as follows.<br><br>1. There was a ten-day delay in Ms Chappell's transfer from the Princess Royal Hospital to UCLH. I was told that this might have been because of a lack of beds, but it might also have been because of confusion about which UCLH site was the accepting surgeon's preferred destination, a confusion that was understood at the time by the Princess Royal to be a rejection of the transfer.<br><br>2. From at least 16 June 2023, the consultant urology surgeon in charge of Ms Chappell's care was very firmly of the view that he was not the best clinician to fulfil this role. He had long since correctly determined that she had not sustained a ruptured bladder, and thus considered that her care belonged with the gastroenterologists or the general surgeons. Despite the agreement on 16 June of the gastroenterology clinical director that Ms Chappell's care should be led by the gastroenterologists, they had not taken over her care by the time of her death, and there had not even been a conversation between the gastroenterology and general surgery consultants about the transfer of care.<br><br>3. There was a frequent misunderstanding among the medical staff that Ms Chappell's issues were all chronic. Her acute situation was often not properly handed over or understood by her consultants. 3<br><br>4. Whilst at UCLH, the pain relief offered to Ms Chappell (principally simply paracetamol) was completely inadequate. At night, her buzzer was taken away from her and her door was shut.<br><br>5. The management of the nasogastric tube that was crucial in attempting to avoid a fatal aspiration was inappropriate. The tube in situ that was operating effectively was removed |

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| | approximately ten days before her death. Her abdomen became extremely distended. A further tube placement was not attempted until the day before she died. When this proved beyond the nurses' skillset, a doctor was not called to assist until the following afternoon. By then, two experienced doctors were unable to insert a tube and, as they were attending her (with her mother present), their patient suffered a massive aspiration and died shortly afterwards. I was told at inquest that if the nasogastric tube had been passed at an earlier point, this would have been done successfully and the fatal cardiac arrest would have been avoided.<br><br>6. This death occurred almost six months ago, but no proper trust investigation has taken place, no change in policies or procedures has been agreed, and the systems at UCLH remain largely what they were on the day that Sarah Chappell died. |
| 6 | **Action taken/timescale**<br><br>The actions responded to by UCLH relate to all of the concerns (1-6). It is noted that concern number 1 also relates to another provider, the Princess Royal University Hospital in Orpington.<br><br>***1. There was a ten-day delay in Ms Chappell's transfer from the Princess Royal Hospital to UCLH. I was told that this might have been because of a lack of beds, but it might also have been because of confusion about which UCLH site was the accepting surgeon's preferred destination, a confusion that was understood at the time by the Princess Royal to be a rejection of the transfer.***<br><br>**Actions:**<br><br>Ms Chappell was transferred to UCLH as an emergency referral from PRUH on 1st June 2023, as the team there believed she had suffered a perforation of her neobladder. She had been discussed by the PRUH team with a urology consultant on 22 May 2023 and accepted for transfer, however there were no available beds at the time at UCLH. PRUH appear to have organised Ms Chappell's transfer to the UCLH Emergency Department without confirming with the Urology team at UCLH and Ms Chappell was subsequently admitted to a surgical ward (T14 north) when they had a bed available. Ms Chappell was then transferred to T14 Acute Surgical Unit on the evening of 1st June 2023.<br><br>Recognising that there was confusion between PRUH and UCLH relating to transfer we will develop a referral form for urology by May 2024 to improve documentation around the reason for transfer and agreed decisions to inform the plan of care. This will be led by the clinical lead for urology and will mirror some of our best practice referrals such as in the thoracic service.<br><br>Through this investigation process we have now identified that the accepting clinical team did not communicate the patient referral to the co-ordination centre for one week. The co-ordination centre is responsible for managing patient transfers into UCLH. We will include the need to inform the coordination centre in the referral form that we are developing for patients identified as tertiary transfers. This includes the level of clinical priority discussed with the accepting consultant. This will be completed and disseminated by May 2024. |

2. ***From at least 16 June 2023, the consultant urology surgeon in charge of Ms Chappell's care was very firmly of the view that he was not the best clinician to fulfil this role. He had long since correctly determined that she had not sustained a ruptured bladder, and thus considered that her care belonged with the gastroenterologists or the general surgeons. Despite the agreement on 16 June of the gastroenterology clinical director that Ms Chappell's care should be led by the gastroenterologists, they had not taken over her care by the time of her death, and there had not even been a conversation between the gastroenterology and general surgery consultants about the transfer of care.***

3. ***There was a frequent misunderstanding among the medical staff that Ms Chappell's issues were all chronic. Her acute situation was often not properly handed over or understood by her consultants.***

**Actions:**

*For clarification, the clinical director for gastroenterology was not involved in discussions relating to Ms Chappell's care at UCLH: this was undertaken by the clinical lead for gastroenterology.*

On the 16th June 2023 there was a conversation between the urology consultant and the clinical lead for gastroenterology, culminating in a request for either joint care or gastroenterology input into Ms Chappell's care. There was no agreement for joint care in place but agreement for the appropriate gastroenterology specialist teams (nutrition and neurogastroenterology) to review Ms Chappell, which subsequently occurred on the 16th June 2023.

We completely recognise that clearer processes both around joint care and escalation of decisions on ownership of care if there are disagreements are required. We will review our processes for allocating the named consultant in charge, agreeing joint care and escalation processes when there is disagreement over the named consultant by May 2024.

4. ***Whilst at UCLH, the pain relief offered to Ms Chappell (principally simply paracetamol) was completely inadequate.***

**Actions:**

Ms Chappell was given morphine and regular intravenous paracetamol for pain relief. When administered intravenously (as opposed to orally), paracetamol can be as effective as intravenous morphine but without the side effects such as drowsiness, nausea and lowered respiratory rate. On 3rd June 2023, Ms Chappell's respiratory rate and oxygen levels dropped following morphine administration for pain. This led to Ms Chappell requiring naloxone to reverse the effects of the morphine.

It is evident that this experience made Ms Chappell worried about taking her pain relief and there is documentation that the nurse and doctors spent time with her discussing her pain medication.

According to her medical records, Ms Chappell preferred to be repositioned regularly to help with the pain instead of taking stronger pain relief. 1:1 care was provided for Ms Chappell to more regularly assess and respond to her needs, including pain.

The complex pain team reviewed Ms Chappell on 5 June 2023, and did not think Ms Chappell had chronic pain so they requested a review by the acute pain team. We recognise there was a delay for this acute pain review to be undertaken.

We have since launched a nurse-in-charge dashboard (in January 2024) which incorporates a pain review. This is a live dashboard which allows the nurse-in-charge to rapidly view quality and safety metrics, such as pain scores, for all patients.

We also recognise there are improvements required around monitoring response times to pain team referrals and evaluating impact. We will undertake a service review of the pain team by May 2024, led by the head of nursing for Surgery and Cancer Board, to understand gaps in the service and to identify systems and processes for improvement. This review will report to the pain steering group by July 2024.

**4.** ***At night, her buzzer was taken away from her and her door was shut.***

Overnight on 14 June 2023 it was documented that Ms Chappell had called her Mum, [redacted] as she could not locate/see her buzzer. A staff nurse gave Ms Chappell her buzzer and apologised over the phone to [redacted] at that time. Ms Chappell's buzzer was not removed from her but at times she did have trouble locating it in her bed. Ms Chappell's door was closed when undertaking personal care but was not routinely kept shut.

Whilst we were responsive to Ms Chappell's concern about her buzzer we recognise that vulnerable patient groups may require enhanced levels of care and observation to ensure easy access to communication aids. In January 2024 we convened a mental health and enhanced observations programme board, chaired by the chief nurse. This group provides assurance to the nursing & midwifery board and senior directors team that the assessment, delivery and evaluation of care meets the needs of people requiring enhanced care.

To supplement the [redacted] training we have delivered bespoke training to 612 staff between April-September 2023. This training is designed to improve understanding of hospital passports and the care needs of people with a learning disability. Furthermore, ADD-Vance, an external provider, delivered 8 commissioned sessions between April-June 2023 for 100 staff on "Understanding Autism and ADHD". Feedback from staff was extremely positive.

In January 2024 we launched patient stories via video to share patient experiences and improve staff understanding of different patient populations and care needs. The first story we co-produced focussed on the experience of a patient with a learning disability. This was presented at the trust board in January 2023.

**5.** ***The management of the nasogastric tube that was crucial in attempting to avoid a fatal aspiration was inappropriate. The tube in situ that was operating effectively was removed approximately ten days before her death. Her abdomen became***

***extremely distended. A further tube placement was not attempted until the day before she died. When this proved beyond the nurses' skillset, a doctor was not called to assist until the following afternoon. By then, two experienced doctors were unable to insert a tube and, as they were attending her (with her mother present), their patient suffered a massive aspiration and died shortly afterwards. I was told at inquest that if the nasogastric tube had been passed at an earlier point, this would have been done successfully and the fatal cardiac arrest would have been avoided.***

**Actions:**

Ms Chappell was admitted to UCLH with a nasogastric (NG) tube from PRUH on 1st June 2023. The NG tube was removed on 10th June 2023 due to low drainage volume which is appropriate practice. A NG tube can be uncomfortable for patients and prolonged placement can cause inflammation of the oesophagus. We therefore remove them if they are not required. Following a scan on 22nd June there was a request for a new, larger NG to be inserted. Nasogastric tube insertion can be difficult and not predictable as to which in which patients such insertion may not succeed. However, we recognise there were multiple attempts to insert the larger NG tube and that there were failings in the escalation of a difficult NG tube insertion.

We will update our policy on NG insertion to include a section on the placement of NG tubes in the context of surgical drainage and the escalation process for difficult/unsuccessful NG tube placement. This will be completed by March 2024.

We will also update our bowel obstruction flow chart by March 2024 to ensure it includes escalation procedures and timelines.

6. ***This death occurred almost six months ago, but no proper trust investigation has taken place, no change in policies or procedures has been agreed, and the systems at UCLH remain largely what they were on the day that Sarah Chappell died.***

**Actions:**

A 72 hour cardiac arrest rapid review was undertaken on 3rd July 2023. This culminated in an after-action review with a robust and detailed action plan. There was a delay to producing the action plan (October 2023) and we recognise this as a concern.

In January 2023 we instigated a process as part of our mortality surveillance group to review all patients with a learning disability who die at UCLH. This group is chaired by the corporate medical director and attended by multi-professional group including the learning disability team, quality & safety team and structured judgement review leads.

In October 2023 we convened a weekly, multi-professional trust wide incident review group that reviews moderate harm incidents, allowing us to better identify and disseminate learning following the introduction of the Patient Safety and Incident Response Framework (PSIRF).

In June 2023 we actively promoted Learning Disability Awareness Week with support from the learning disability nurses, chief nurse and chief executive. Newly published hospital communication support books were handed out across the trust with very positive feedback.

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| | An online version is available on the intranet for staff to access. The safeguarding team will evaluate the effectiveness of the books and share with the learning disability steering group.<br><br>In addition, a subgroup of the Learning Disability Steering Group will be convened in February 2024 to review all incidents involving patients with a learning disability, including those resulting in no harm. The subgroup aims to improve learning and inform improvements at an individual, team, organisational and system level, with quarterly reporting of key themes to the nursing & midwifery board and senior directors team. |
| 7 | **This response has been prepared by**<br><br>[redacted], Deputy Chief Nurse on behalf of the chief nurse |
| 8 | **Date of response**<br><br>5th February 2024 |

Yours sincerely,

[redacted]

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**Chief Nurse**

cc: [redacted], Director for Quality and Safety, UCLH
[redacted], Claims & Inquests Manager, UCLH