Barts Health
NHS Trust

Trust Headquarters
Executive Offices
Ground Floor
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
London
E1 2ES

Our ref: ID406705
Your ref: 20918500

Date: 09 July 2024

Private & Confidential

East London Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Dear HM Coroner,

Thank you for your letter dated 13 May 2024 following the inquest of Mr Elvon Paul Randolph Morton 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 have an impact across the Barts Health group.

This response is based on information provided by:

[redacted], Clinical Lead, Emergency Medicine
[redacted], Clincal Director for Speciality Medicine
[redacted], Clinical Director Surgery Division

Your concerns and our response

1. **Documentation of key stages in Mr Morton's care was poor or non-existent. Critical decisions on; mental capacity, best interests, the choice of sedation, the amount of drug administered, the method of administration and the timing of administration were not clearly recorded. In multi-clinician treatment contemporary documentation is essential to preserve patient safety. In this case the lack of clear documentation meant that some clinicians were unaware that Elvon was sedated, whilst others were ignorant of the fact that he had declined treatment.**

The teams acknowledge that the documentation at all levels is suboptimal. There was no consultant documentation or contemporaneous documentation on Millenium (the electronic healthcare system) or on paper. The consultant's remote access had lapsed so they were unable to access the system, but they did not arrange a retrospective entry when access was available. The documentation of discussion with intensive care unit (ITU) specialist registrar (SPR) and Accident and Emergency (A&E) consultant on call indicates brief response to what was a much more detailed discussion.

A specific induction programme has been formulated for the A&E which specifically covers themes such as the mental capacity act, contemporaneous documentation including emergency administered drugs with rationale, sedation and also escalation. The induction programme will be delivered and evidenced retained. A specific presentation relating to the Mental Capacity Act (MCA) its implementation in practice and the wider considerations will be delivered within the teaching programmes for all grades within A&E.

All doctors starting with ITU receive written pre-induction material to orientate them to the service. This is supplemented with face-to-face departmental induction. The induction material has been updated to state very clearly the need for contemporaneous documentation of clinical decision making wherever possible. Where not possible the documentation should reflect a retrospective entry with reasons why the entry had to be deferred.

The speciality medicine team have a teaching programme and induction of all levels of staff on Internal Professional standards and appropriate contemporaneous documentation. Training will also be provided to all staff grades to ensure that they understand how to assess mental capacity and the application of deprivation of liberty safeguards (DoLS).

Teams will ensure that consultants on call confirm that they have remote access to the electronic healthcare record, this will eliminate the risk that documentation is not completed in relation to critical decisions.

2. **Witnesses blamed poor documentation on workload, specifically an influx of acute patients into the resuscitation bays. Despite this, no evidence was presented that any attempt was made to mitigate this pressure by, escalating the matter to the site manager, nor did the on-call ED consultant find it necessary to come into the unit. These actions tend towards a "coping culture" inconsistent with patient safety.**

The Trust are supportive of staff that are increasingly managing high numbers of complex and acutely unwell patients. In this case, doctors sought and were provided with advice from a consultant on call. The consultant on call will attend to perform certain procedures (in line with the Royal College of Emergency Medicine guidance). With the benefit of hindsight, consultant presence would have provided support for the trainees.

The clinical review group agree that a wider discussion needs to take place to review WXH A&E working patterns and consultant cover, these discussions are complex and will likely take place over the next 12 months in conjunction with other improvement work being undertaken to manage patient flow within the hospital. Risks in relation to ED pressures including overcrowding and resus capacity are reflected on the WXH risk register.

3. **The decision to sedate Mr Morton was flawed. The lack of contemporary documentation impeded an effective coronial investigation and review of that clinical decision. In the absence of clear and reasoned evidence of decision making, weight must be attached to evidence heard that, Elvon's; size, sex and race triggered a heightened response by hospital staff to his agitation, leading to security officers being called. It was in this febrile atmosphere that the decision to utilise rapid tranquilisation, a simpler and faster process than anaesthesia and intubation, was made.**

   There is permanent security presence in the emergency department (ED) to protect patients and staff from people who pose a risk to themselves and others. The decision to seek security support is based on a dynamic risk assessment and whilst the Trust acknowledge the lack of documentation support was sought to maintain the patient's safety to support clinical management and risks associated with leaving the department against clinical advice.

   The Trust accept and apologise for the fact that the documentation available to the coroner impeded investigation and decision making. The clinical view from the ITU mortality and morbidity meeting and additional post inquest clinical review is that, considering the degree of metabolic derangement, this patient would likely still have suffered a cardiac arrest on induction of anaesthesia, and clinical outcome most likely to have been the same as that consequent to cardiac arrest secondary to the administration of sedation.

   For assurance and complete clarity, the new rapid tranquilisation guidance which in the process of being recently updated is applicable to the whole of Barts Health has a very clear wording at the top "This guidance is not to be used in the hypoxic, hypovolemic or septic patient or in one in which intubation as opposed to rapid tranquilisation is required". This will ensure decision making is senior and clearly documented if and when the guidance cannot be followed in cases where there is sound clinical justification to do so.

4. **A failure in governance at the Trust meant that this case was not identified as a serious incident. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the trust to identify, reflect upon, and remediate sub-optimal practice.**

This patient's death on 7 December 2022 was unexpected and was reported as an incident via the Datix reporting system but it was not presented for multidisciplinary team (MDT) discussion as a serious incident. The fail safe whereby a mortality and morbidity meeting triggers Serious Incident Review Assurance Panel (SIRMAP) discussion did not happen because although learning was identified the outcome was not felt to have been due to failures in care. Following a prompt from HM Coroner via the legal team, the case was presented to SIRMAP in July 2023 and the panel identified learning but did not find that the outcome could have been altered in this case.

Since November 2023, WXH have been in the process of implementing the Patient Safety Incident Response Framework. There is a very clear directive that unexpected deaths need to be reported via Datix and presented at Patient Safety Incident Review Meeting (PSIRM) so that an MDT decision can be made in terms of the correct learning response. In cases where care is thought to have led to the patient's death a PSII will be undertaken (these investigations can take up to 6 months to complete). In other cases, an After-Action Review or SWARM huddle (where staff 'swarm' to review an incident) will be undertaken, these need to be completed within 12 weeks. In other cases, the PSIRM chair will request that the case be presented to M&M and the outcome reported back to PSIRM.

WXH have very carefully considered PFDs issued by the coroner in conjunction with late submissions and the impact this has on families, HM Coroner and ensuring preparedness for inquests. Steps have been taken to ensure that specialities have early sight of inquests. This will ensure that cases are reported via Datix, presented to PSIRM, learning responses and other key documentation are submitted in a timely manner (including statements). A proposal has been prepared to recruit a learning from deaths lead, their primary responsibility would be to drive improvement with stakeholder engagement including families, MEs, and coroners.

The Trust deeply regret the concerns raised by HM Coroner and the impact the inquest findings will have had on the patient's family. Arrangements will be made to share this letter with the patient's family and an offer 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 Mr Morton's death. If you have any queries, please do not hesitate to contact me.

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Yours sincerely

[redacted]

Group Chief Medical Officer
Barts Health NHS Trust