NHS
Barking, Havering and Redbridge
University Hospitals
NHS Trust

Private & Confidential
Mr G Irvine
HM Area Coroner
Walthamstow Coroner's Court
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Legal Services Department
Queen's Hospital
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Sent Via Email

21 August 2024

Dear Sir,

Regulation 28 Report on the death of Mr David Morris – Ref: [redacted]

Thank you for your Regulation 28 Report of 04 July 2024. Barking, Havering and Redbridge University Hospitals NHS Trust (the Trust) has carefully considered the matters of concern raised by the learned Coroner in the Regulation 28 Report, and guidance has been sought from specialists within the Trust to address them.

I will now outline the matters identified in the Regulation 28 Report, and address them in turn:

1. ***Mr Morris's diagnosis and treatment for cancer was delayed due to poor organisation and communication at the Trust.***

Mr Morris's treatment plan and diagnosis was delayed and complicated in part due to being downgraded in severity on the Patient Tracker List which led to a breakdown in communication between clinical pathways. With Immediate effect, no patients that are currently on a Patient Tracker List for any cancer diagnosis can be removed or deferred without approval of the responsible consultant. This is to ensure that administrative processes have a clear oversight of a senior clinician who takes full responsibility for the treatment plan.

In addition, a restructure of the cancer administration pathways is underway by the Speciality Manager for cancer performance; under the oversight of the Chief Operating Officer. This restructure is proposed to finish by 30 September 2024, with its implementation expected to result in new clinical oversight and streamlined communication.

2. ***During the evening of 3rd May 2022 going into the early hours of 4th May 2022, Doctors and nurses failed to identify the extent of Mr Morris's gastrostomy leak and the onset of sepsis. After identifying symptoms of sepsis, staff failed to treat and escalate Mr Morris's care resulting in a delay of three and a half hours before a medical review commenced emergency treatment.***

The Trust has implemented an increase in our Critical Care Outreach Team (CCOT) model since April 2024. Previously this service was offered between the hours of 8am to 8pm with no dedicated service outside of these hours. Since April 2024 this is now a dedicated twenty-four-hour service delivered seven days a week to ensure continuity and access to specialised teams as required.

This team visits patients within the ward environment and provides local therapeutic intervention to decrease the likelihood of requiring higher dependency treatment. The CCOT team is also a source of escalation for staff when they feel that a patient is deteriorating, and this is done in conjunction with informing the medical team.

Additionally, the Trust is currently in the process of designing and implementing Martha's Rule, which is based upon the case of Martha Mills who died in 2021 after developing sepsis in hospital. In response to hers and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implementing 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Formal launch is planned for November 2024 and its implementation will enable patients and relatives to also refer to this service independently; and enable a review of any patient with a perceived deterioration. In particular, the focus of Martha's rule for BHRUT includes:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.

2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.

Finally, there is now a deteriorating patient panel group which meets weekly and reviews patients that have had a deterioration in clinical condition and uses this information/learning to change practice both locally and Trust-wide. To assist in the familiarity of the process and policy for deteriorating patients, this is now included in Basic Life Support training which is an essential requirement for all clinical staff. There is also a development of an online training for the recognition of deteriorating patients.

3. During Mr Morris's ward-based treatment on 3rd & 4th May 2022 clinical records were either of a poor standard or were non-existent. The absence of clear records impeded the effective investigation of this death by the Trust's governance teams and the Coroner.

The standard of documentation was highlighted as being of a poor quality. The Trust is in the process of preparing for the introduction of an Electronic Patient Records (EPR) system, which is due to be adopted in May 2025. Adopting the EPR system will involve a process where contemporaneous and clear clinical documentation is made during clinical episodes of care; and this practice will be highlighted as a mandatory part of the medical and nursing induction process for all new starters.

In August 2024, the Medical Directorate has established a Quarterly Health Records Group where both best practice and learning opportunities will be presented and reviewed with action plans as appropriate.

In addition, the Trust lead for mortality is reviewing the possibility of performing CRABEL audits (an audit tool designed by CRAwford – BEresford – Lafferty) as a tool for the assessment of the quality of medical record keeping, with the ability to standardise audit and improvement across areas. A plan is due to be presented for approval in November 2024 following the second meeting of the Health Records Group.

4. The initial serious investigation report into Mr Morris's death was unfit for purpose. The report to investigate or even identify the Registrar who reviewed Mr Morris on the evening of 3rd May 2022. Since then, no effective review has been undertaken by the Trust upon how this deficient report gained executive approval.

Since October 2023 there has been a change in the process of investigating significant patient safety incidents at BHRUT. This has now been changed to the Patient Safety Investigation Response Framework (PSIRF) which uses multidisciplinary investigations and reviews with multiple responsible authors. In line with NHS England guidance, the Investigating Officer is centrally allocated by the Quality and Safety team and, whenever possible, these are allocated outside of the Clinical Group where the incident occurred.

There is a weekly Incident Oversight Learning Group (IOLG) whereby all incidents that are considered of concern are discussed with specific terms of reference. This includes background information and a review of the entire pathway which a patient has encountered when systems issues are identified; thereby including any omissions that may have occurred with the previous Serious Incident Framework. The Incident Oversight Learning Group meetings are chaired by either the Medical Director for Patient Safety and Patient Experience or the Director of Nursing for Quality and Safety, and this group decides when to commission a further PSIRF learning response.

On completion of Patient Safety Incident Investigations (PSIIs) there is a Learning Review Group (LRG) which reviews the contents of the reports to ensure adequate exploration of key issues has occurred; that the family has had an opportunity to input into the investigation; and ensures the improvement action plan both aligns with learning identified and is sufficiently robust to counteract the existing safety issues identified. The Terms of Reference for this meeting have been updated and now include a Board Executive (or nominated deputy) who must be in attendance for quoracy when signing off investigations.

For additional oversight and support, colleagues from the North East London Integrated Care Board (ICB) are members of all improvement and review panels, including the IOLG and the LRG. Once reports are approved by the Medical Director for Patient Safety and Patient Experience, in conjunction with the Director of Nursing for Quality and Safety, they are submitted to the ICB who monitor learning from provider organisations and use this information to share insights across organisations and services to improve safety across the Integrated Care System.

5. ***The Trust did not have effective controlled drug management systems in place to detect a prolonged and persistent course of conduct from an employed nurse who was stealing and self-administering controlled drugs in the workplace.***

In light of the concerns raised by the learned Coroner, the Trust is trialing a digital key system on each ward, together with exploring installing CCTV into the Medicine Preparation rooms. An initial discussion with suppliers took place in July 2024.

An external review of the Controlled Medication practices is currently being planned for September 2024 by the Metropolitan Police Controlled Drug Liaison Officer. It is envisaged that the Metropolitan Police Controlled Drug Liaison Officer would provide an external review and highlight areas of concern that will be taken forwards by the Pharmacy team for action as required.

To assist with compliance with the medication policies, a Medicine Management Nurse is being introduced within the Trust and the recruitment process is currently underway. Advertising of the post should begin in October 2024 with appointment following this.

A change in the process of Controlled Medication Keys is already in place since the incident, with individuals identified at the start of each shift with sole responsibility and ownership of these.

At the learned Coroner's request during inquest, the Trust reached out to the previous employee who had been removing controlled medication without authorisation, but the employee unfortunately did not respond.

The Trust has taken the issues identified by the learned Coroner very seriously, and taken positive action to address them.

I would be happy to meet to discuss this response if that would be helpful to the learned Coroner.

Yours sincerely,

[redacted]

[redacted]
Chief Executive