NHS
County Durham
and Darlington
NHS Foundation Trust

Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington,
DL3 6HX
E-mail: [redacted]

Our Ref: [redacted]

13th September 2024

Ms. Janine Richards,
Assistant HM Coroner,
County Durham

Dear Ms Richards,

Re: Janet Rice

We are writing in response to your request for the Trust to take action in relation to concerns as detailed below:

(1) The final version of the patient safety investigation report carried out by the Trust was only received on the first day of the Inquest, some 16 months after the death. The concerns raised in this Inquest have been well known to the Trust for a considerable period of time and the concern is that lessons cannot be learned in a timely fashion if patient safety investigations are so significantly delayed.

(2) The patient safety investigation report is not a comprehensive and robust review of the omissions in provision of anti-coagulant and does not consider or address the omission to administer anti-coagulant because the deceased was transferred between hospitals, nor does it detail all of the incidents of missed anti-coagulant, some of which only became apparent upon receipt of the independent expert report. It's remit and action plan are limited to the community hospital only, and do not consider or address the further instances of omission to administer anti-coagulant in the acute hospital setting, where there was a continued failure to carry out a capacity assessment and any subsequent best interests decision making process, failure to escalate these issues, and/or to consider any alternative treatment to reduce the high risk of DVT/PE.

(3) Although evidence was heard in relation to the provision of further training in relation to the issues of capacity and best interests decision making, to address the concerns identified in this investigation this was limited to the community hospital setting, when it is known that the issues continued in the acute hospital setting.

The Trust would like to offer its sincere condolences to Janet's family for their loss. We take very seriously the concerns which you have raised and have provided a response below.

The final version of the patient safety investigation report carried out by the Trust was only received on the first day of the Inquest, some 16 months after the death. The concerns raised in this Inquest have been well known to the Trust for a considerable period of time and the concern is that lessons cannot be learned in a timely fashion if patient safety investigations are so significantly delayed.

The Trust has robust processes in place in relation to the investigation of any patient safety incidents identified. When the Trust were made aware that there were patient safety concerns relating to Janet's care, in April 2024, a review commenced of her care led by one of the Community matrons. The time taken to conclude and ensure the report had progressed through the appropriate Trust governance resulted in the report not being available to yourself until the morning of the inquest. However we recognise that this was not an acceptable timeframe to enable you to properly review the report. Whilst the progress of patient safety investigations have always been tracked by the corporate patient safety team, additional processes have now been established whereby these cases are tracked at the weekly Friday Senior Clinical Leaders patient safety forum.

The patient safety investigation report is not a comprehensive and robust review of the omissions in provision of anti-coagulant and does not consider or address the omission to administer anti-coagulant because the deceased was transferred between hospitals, nor does it detail all of the incidents of missed anti-coagulant, some of which only became apparent upon receipt of the independent expert report. It's remit and action plan are limited to the community hospital only, and do not consider or address the further instances of omission to administer anti-coagulant in the acute hospital setting, where there was a continued failure to carry out a capacity assessment and any subsequent best interests decision making process, failure to escalate these issues, and/or to consider any alternative treatment to reduce the high risk of DVT/PE.

The Trust acknowledges this and the report has now been reviewed and updated to ensure that all elements of Janet's care, both acute and community, have been included which is also reflected and incorporated in the action plan (included in Appendix A).

Although evidence was heard in relation to the provision of further training in relation to the issues of capacity and best interests decision making, to address the concerns identified in this investigation this was limited to the community hospital setting, when it is known that the issues continued in the acute hospital setting.

This is addressed in the action plan included in appendix A.

Conclusion
We trust that the responses detailed in this letter are sufficient to address the concerns you have highlighted. However, please feel free to contact us if you need any additional information or have further queries.

Yours sincerely

[redacted]
Executive Director of Nursing

[redacted]
Executive Medical Director

cc. [redacted]

Appendix A: Areas identified that require further action

Safety action description	Safety action owner (role, team, directorate)	Target date for implementation	Plan for monitoring / oversight	Review date
Area for improvement 1: Missed doses of Enoxaparin				
Improve documentation in the clinical records detailing the reason why a patient has refused medication and escalation steps taken. (Community).	Matron [redacted] and ward manager Starling ward staff.	31/7/24 Complete	Information relayed at handovers/ attend daily huddles. Monitor electronic patient records via monthly audits.	31/8/24 Complete
Share learning from the case at Quality and Safety huddle for wider learning (Acute site).	[redacted]	14/9/24 Complete	UEC and medicine Care Group	14/9/24 Complete
Pharmacy attendance at Sister's Away Day to raise awareness of Critical Medications list. (Covers Acute and Community).	[redacted]	30/9/24 Complete	Pharmacy Governance	30/9/24 Complete
Area for improvement 2:				
Carers passports and open visiting (Community).	[redacted]	31/7/24 Complete	Passports ordered. New visiting times and information poster developed and sent for approval.	31/8/24 Complete