Barts Health
NHS Trust

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

Telephone: 020 32460641
Email: [redacted]

Group Chief Medical Officer
[redacted]

www.bartshealth.nhs.uk

PRIVATE & CONFIDENTIAL
24 October 2024

Our Ref: [redacted]
Your Ref: [redacted]

24 October 2024

Mr Graeme Irvine
Area Coroner – East London
Walthamstow Coroner's Court
Queen's Road
London
E17 8QP

Dear Mr Irvine

Re: Regulation 28 Report to Prevent Future Deaths

I write regarding your letter of regarding your concerns relating to the death of Terence Clark at Newham University Hospital. I hope this letter will provide assurance to you of the steps that we are taking to address the concerns you have outlined.

A. Despite Mr Clark having been subject to a nil-by-mouth order for 24 hrs prior to collapse, cream-coloured liquid food was found in Mr Clark's airway at autopsy The NG tube, inserted on the day of death had been removed and misplaced prior to autopsy. No evidence exists to indicate, when the apparatus was removed, by whom, on whose instruction or why. The removal and loss of this apparatus impeded the proper investigation of this death.

B. The Trust conducted a patient safety investigation into the circumstances leading to Mr Clark's death, the investigation did not identify the removal of the NG tube as a significant factor worthy of scrutiny. Both of these issues raise a concern that the Trust can not adequately secure and review evidence relevant to governance and coronial investigations, necessary to mitigate risks of future fatalities.

I will respond to these items together as they are interlinked. Mr Clark had an NG tube inserted on the 1st November 2023. It was not used prior to the X-Ray being conducted at which point Mr Clark had a cardiac arrest and died. The investigation into his death focused on the lack of nursing escort and therefore knowledge of Mr Clark's DNACPR status when he arrested in the department which resulted in CPR being commenced. The NG tube was removed by ward staff on the day of Mr Clark's death following a discussion with a doctor and the site manager. At this point a coroners referral had not been considered or made. The coroner's referral was made on the 3rd November 2023.
The terms of reference for the concise internal investigation into Mr Clark's death did not include review of the NGT removal as it was not considered to be materially relevant to any care issues identified.

I apologise that the information regarding the timing of the removal of the NGT was not provided at the inquest and it was not considered as part of the concise investigation.

The Barts Health Bereavement – care before, during and after death policy, states that where coroners referral has been made, tubes and devices should not be removed and that to contact the coroners office if unsure. It also indicates that this can be discussed ahead of death where relevant.

The current policy differs with regard to removal of tubes and devices according to whether a coroners referral has been made. It also states in section 26.4 that: if the cause of death is known and the coroner is not going to be involved there should be no concern about removing medical tubes and lines.

Following this case, we are reviewing the Bereavement policy to clarify the guidance around removal of tubes, lines and devices. Where a sudden or unexpected death has occurred, the policy will mandate that tubes, lines and devices are left in situ until after:

a. A discussion with the medical examiner
b. A decision has been made about coronial referral
c. A death certificate has been issued

The policy will also be updated to include the role of the medical examiner. Every patient death is now reviewed by a Medical Examiner usually within 24 hours and so the need for a coroner referral should be clear prior to any removal of equipment from the body and a delay of 2 days, as in this case, should be avoided.

This case has already been discussed at our safety huddles, with the senior nursing and site teams to underline the above and ensure a lower threshold for discussion with the coroners office should there be any doubt about removal of lines etc. Any conversation will be documented in the patient record.
We will be cascading the learning from this incident and embedding this within training across the Trust.

Yours sincerely

[redacted]

[redacted]

Chief Medical Officer

Barts Health NHS Trust