Response

Dear Mr Potter

Re: Prevention of Future Deaths Report

I am writing on behalf of the chief executive as a formal response to the Prevention of Future Deaths Report following the inquest into the death of Sophie Ann Dean, date of death 04.09.2023. I write as the Divisional Clinical Director for GI Services at University College London Hospital (UCLH). There were three main concerns identified by yourself necessitating action by UCLH.

1. Quality of ward round documentation by junior staff, including omissions of key discussions and assessments
2. Omissions from the medical records for Miss Dean's admission
3. Lack of evidence of adequately documented consent with parents

Following consultation with our medical and surgical teams, UCLH has enacted the following:

1. Each subpecialty team will decide on a standard ward round note to include an agreed minimum requirement for information. This may include, for example, the last set of observations, most recent blood tests or radiology findings, and documentation of the senior doctor leading the ward round. UCLH uses an electronic healthcare record system that allows personalisation of a standard ward round template, which is available across workstations and mobile devices, to facilitate delivery. Each division has agreed to perform a notes audit within the next 12 months to ensure this standard is being upheld.

2. The surgeon involved has reflected on the omissions from the medical records and recognised that the discussion he had with the radiologist and then with the family was not appropriately recorded in the notes. He has made a non-contemporaneous record to reflect these discussions.

3. The consent policy has been amended to state that where there is agreed to be a high risk of surgical mortality (determined to be a 10% risk) in patients unable to provide informed consent who are undergoing an emergency surgical procedure, a second consultant opinion will be sought and the second consultant will document in the electronic record their opinion. In non-emergency situations, a Best Interests Meeting will convene and the outcome documented. In all cases, documentation will include the risks of performing the surgery, and the converse risks of doing nothing and continuing conservative treatment only.

   Documentation of speciality agreement to implement this new policy will occur through local governance committees. This will be audited within six months.

The learning from this PFD will be incorporated into Trust induction on a subspecialty level, to ensure the ward round documentation requirements are clear for future resident doctors and there is familiarity with the consent policy. This timeline for this is three months for completion.

It is our sincere belief that these changes outlined, as well as the means of confirming that processes are being followed, will allow UCLH to meet the requirements of the PFD report and to help prevent future challenges to patient safety.

I am, of course, very happy to provide more information on the above if required, please do not hesitate to get in touch.

Yours sincerely

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Consultant Gastroenterologist and GI Services Divisional Clinical Director