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Private and Confidential
Mr G Irvine
HM Area Coroner
Walthamstow Coroner's Court
Queens Road
London

Date: 18 December 2024

Regulation 28 Report on the death of Miss Chloe Every- Reference:

Dear Mr Irvine,

Thank you for your Regulation 28 Report of 25 October 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.

The matters of concern identified in the Regulation 28 report and the Trust`s responses are set out below

- **The Trust does not provide nursing cover during weekends and holiday periods of staff with relevant learning disability training.**

It was submitted in evidence at the hearing that the Trust has made efforts to recruit qualified Learning Disability nurses to provide cover during weekends and holiday periods. The absence of nursing cover at these times is not a matter of a lack of resource, but an issue with having a cohort of available, recruitable nurses with this specific qualification. Our review identified that no acute Trust in London has Learning Disability nurses on a 24/7 basis.

In recognising this limitation, the Trust has put mitigations in place. The Trust provides mandatory training for all staff including both nursing and medical staff related to the care of patients with a Learning Disability. The training covers a broad range of topics which include diagnostic overshadowing, the importance of reasonable adjustments and how to access resources to support patients with a Learning Disability whilst they are under the care of the Trust. The aim of the training is to alert staff to understand the requirements of patients with a Learning Disability and to be aware of the reasonable adjustments required that will support patients and ensure that they receive the care that they need.

All staff are expected to complete the Oliver McGowan training which is a national standardised training requirement. The training is designed to provide staff with better skills, knowledge and understanding of the needs of autistic people and people with a Learning Disability. The Trust implemented internal face to face level 3 Learning Disability training for staff including sharing the experience of a patient with Learning Disability and their interaction with clinical staff to promote best practice.

The Trust's Learning Disability Team (LD team) review patients in the wards and ensure that staff have the required support to deliver care to patients. This team operates across both sites and are accessible by telephone and email.

The hospital IT system is able to identify when patients with a Learning Disability have been admitted or are being cared for within the hospital. The team produces a report daily via the Trust IT system which identifies if new patients with a Learning Disability have been admitted. They then review the patient in person on the ward the next working day ensuring that appropriate clinicians and professionals are informed of the admission. Daily follow ups continue throughout a patient's stay to ensure that appropriate support is provided to the ward area, the patient, and their carers.

There is a practice development nurse who supports the training needs of staff on the ward. The needs are identified by feedback from the Ward Accreditation assessment process, information from the Senior Nurse for Learning Disability and from audits completed. The ward accreditation is a process by which ward areas are assessed by Subject Matter Experts across 11 standards which include reviews by the Learning Disability teams.

There are ongoing plans to employ more nurses with Learning Disabilities qualifications in the Trust which will include the acute ward and emergency department (ED) areas; the recruitment process is underway. The nurses will work in the clinical areas as part of the workforce and will be allocated to care for patients with Learning Disabilities within their area.

- **The investigation of this inquest was prejudiced by the absence of contemporary nursing and medical notes from various stages of Chloe's treatment. The extent of these lapses meant staff who made important treatment decisions could not be identified, and where staff could be identified, no contemporary account of their rationale for making treatment decisions could be located.**

The Trust currently remains on part electronic and paper records. However, there has been significant progress towards a more integrated system. The Trust is in the planning stages of implementation of a full Electronic Patient Care Record (EPR) with the planned date for implementation of June 2025. Implementation is supported by a team of clinical and digital staff, with progress monitored through the Trust Executive Committee and the Trust Board.

As a practical response to this concern, the Trust's Legal Services Department now routinely deliver training sessions on "*The importance of Good Record Keeping*". The training puts particular focus on the importance of good medical documentation being a fundamental aspect of clinicians' duty in providing patient care; ensuring patient's needs are met; ensuring continuity of care; ensuring effective evidence of the standard of care and decision-making process.

Good Medical Record training is being delivered in December 2024 and January 2025 as part of the junior doctors' induction in ED. Consideration is being given to adding this training to all junior doctors' inductions, and as part of the Trust's Statutory and Mandatory training for clinical staff.

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

The Trust lead for mortality and Caldicott Guardian is in the process of organising 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 paper-based CRABEL audit is being undertaken within different specialties and results will be shared trust wide.

An online audit tool has been developed (it is currently at the ready for testing stage to ensure data is captured and reported correctly using an electronic risk management system) and the Trust is aiming to commence auditing across all specialties from February 2025.

- **The regularity of Chloe's clinical observations fell well below the expected level. The lapses included a period of over 10 hours in which no observations were undertaken.**

There is live data in the format of a dashboard showing compliance with expected observation frequency available to senior staff within clinical areas (ward managers, matrons, practice development nurses and clinical group directors). Additional monthly performance reports have been sent to the same staffing groups since December 2023. Vital signs recording and actions form part of the Ward Accreditation Framework process and clinical areas work with the VitalPac team to continue to improve the timings of observations.

The wards areas in the Trust are subject to assessment utilising the Ward Accreditation Framework (WAF) which monitors metrics related to patient care and safety, as well as how the wards are operated. Audits are completed annually by subject matter experts and any areas in which the ward falls below 70% compliance is addressed with an action plan. The WAF framework assesses the nursing staff knowledge of the escalation process for deteriorating patients. The Ward Accreditation assessments started in 2020 and since then all wards in the Trust have completed and have achieved a minimum of a bronze standard for ward accreditation with many at Silver and working towards gold.

Monthly deteriorating patients' audits are carried out by ward areas and are discussed at governance meetings within the Clinical Groups. The Trust also undertakes regular audits of NEWS recording and escalations in compliance with NHS England Commissioning for Quality and Innovation (CQUIN) framework for NEWs escalation and response.

The Trust has funded and implemented a 24 hour a day Critical Care Outreach Team (CCOT) and the team reviews observations using a tracking process on the Clinical Vitals App in all ward areas to ensure that patients who have raised NEWS 2 score have been escalated and reviewed. CCOT monitors patients across the Trust and reviews the Clinical Vitals app within CareFlow to identify patients with elevated NEWS 2 scores (a national early warning system for identifying patients at risk of deterioration). These reviews are undertaken a minimum of three times a day. This is alongside the prompts for escalation that are raised at the time that an elevated NEWS 2 score is entered into the Clinical Vitals system.

- **Chloe underwent an enema on 08 May 2019 without informed consent being taken. The court found that Chloe was unconscious, before, during, and after the procedure, it is possible this procedure contributed to her death.**

The Trust's Consent to Examination and Treatment policy section 4.1.4 'Procedures to follow when patients lack capacity to give or withhold consent' includes guidance on when and how to apply. The policy will be updated by February 2025 to include guidance on implied consent**.**

An Easy Read leaflet on Information about Consent for patients with Learning Disabilities has been drafted and is currently going through review and approval processes with expected completion in February 2025.

The Legal team will deliver training about informed consent including Montgomery Law and GMC and NMC requirements in January 2025.

- **Nursing staff were incapable of explaining to the court the appropriate criteria that would have to exist before commencing CPR on an unresponsive patient.**

All staff are required to complete annual mandatory resuscitation training at different levels depending on their job roles. Trust staff statutory mandatory resuscitation training aligns with NHS England, UK Core Skills Training for Health Framework and 2021 Resuscitation Council UK guidelines. The Training Needs Analysis can evidence cross-Trust resuscitation training, logistical and financial demands, and more accurate monitoring of mandatory compliance metrics in resuscitation training levels 1-3.

In addition, the Trust have introduced mandatory training related to identification and escalation of the acutely deteriorating patient for all patient facing nursing staff in October 2024. Training needs analysis for medical staff is in progress. CCOT provides a deteriorating patient session during Trust induction and on Keeping in Touch (KIT) days, as well as targeted local training in clinical areas on request and when learning is identified following incidents.

The Trust's Resuscitation Service has an audit programme to ensure compliance against published standards. NCEPOD recommends that every CPR attempt is reported through the organisation's incident reporting system; the Trust is compliant with this recommendation and an ongoing audit on reported incidents for cardiac arrests and medical emergencies is being undertaken. The Trust is taking part in the National Cardiac Arrest Audit. Audit of DNACPR policies is mandated as per Health Services Circular and is being undertaken as a part of the Ward Accreditation programme.

In addition, test bleep/dect calls audits are ongoing and help to ensure only relevant personnel receive emergency calls. All audit results are presented at the Resuscitation Committee and reported quarterly to Quality Governance Steering Group.

- **Governance processes at the Trust failed to identify that Chloe's death constituted a patient safety incident until months after her death. A mortality review authored by the Associate Medical Director on 17 May 2019 assessed Chloe's care as good or excellent.**

The incident form was completed on 08 May 2019 following the cardiac arrest as per NCEPOD recommendations. The mortality review was performed in accordance with the RCP Structured Judgement Review guidance. That guidance is reflected in the Trust Learning from Deaths policy which was adhered to in this case. The mortality review is a desktop case note review to identify quality judgments over phases of care. It is not, and is not intended to be, a detailed or final review of care.

The Trust commissioned, from external experts, a review of the Resuscitation Services provided by the Trust. As a result of the review, the Trust's Resuscitation Services was established in March 2022. The service reviews all Cardiac and Emergency calls and mandates the reporting of all calls on the incident reporting system. The service comprises a team of 6 members of staff who are able to support both the teaching and review of deteriorating patients.

There is a Medical Lead for Resuscitation and there are regular Trust wide resuscitation meetings. All cardiac arrests are attended by the Resuscitation team and debriefs are offered.

The Resuscitation team receives the switchboard calls list (one day retrospectively or post weekend Fri-Sun). This information is collated within a database for an understanding of time, date and location; it presents an opportunity to review thematic trends. Identified cardiac arrest calls are triangulated using clinical presence, documentation on CareFlow (the Trust IT system), incident forms submission or retrospective review, if out of hours (this also supports legitimate submission to the National Cardiac Arrest Audit).

The Deteriorating Patient proforma is sent to colleagues at the incident location and following a review by CCOT and Resus, this is presented at the Deteriorating Patient Group to analyse the process of deterioration and identify any learning opportunity. Invites are shared with colleagues who submitted the incident form to present the case, receive feedback and cascade any identified learning within their place of work. If significant learning is identified, this is shared with Incident Oversight and Learning Group and may require a prospective learning response in line with PSIRF (Patient Safety Incident Response Framework).

- **A Serious incident report completed by the trust in the second half of 2019 failed to identify a series of healthcare failings in Chloe's treatment. Management failings at the Trust meant that Chloe's death was not reported to a Coroner until August 2023, by which time Chloe's body had been cremated denying the court an opportunity to gather relevant evidence through autopsy.**

The Trust informed the Coroner that family concerns were expressed from the 17 May 2019 which led to a case review that followed the Learning from Deaths RCP guidance. The Trust advised in the referral form from 2019 that they did not see any reason to delay the funeral and had not found significant events relating to cause and mechanism of death. The cause of death offered by the Trust was 1a) Advanced Cancer and part 2) Myotonic Dystrophy.

Since September 2024 all deaths have been reviewed by the Medical Examiner Office. The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it
- discuss the cause of death with bereaved people and establish if they have questions or any concerns with care before death
- act as a medical advice resource for the local Coroner
- identify cases for further review under local mortality arrangements and contribute to other clinical governance processes.

The SI investigation found care and service delivery problems but did not identify that any of these contributed to Chloe's death. It did not explore the cause of Chloe's cardiac arrest nor the prescribing of morphine, cornerstones of the family's complaints. Due to how significantly unwell Chloe was during this admission, it was not felt that the cardiac arrest was unexpected which may have impacted on the lack of focus on this within the initial investigation.

In July 2024, the Learning Review Group was established. The Learning Review Group undertakes an oversight function to assess the quality of learning responses and adherence with PSIRF methodology. This multi-professional group ensures an appropriate systems-based approach has been used to extract learning from learning responses and develop robust improvement actions, as well as ensuring that compassionate engagement with patients, families and staff has been central to the learning response.

The Trust is monitoring implementation of the safety actions arising from learning responses via the Improvement Oversight Panel (IOP) which was implemented in July 2024. This panel oversees the effectiveness of safety actions and wider safety improvement plans to ensure they are delivering the required improvement. The panel will consider whether sufficient evidence is available of sustainable improvement, prior to closure of the relevant patient safety incidents, or where it is absent, consider what further improvement actions are needed.

All Patient Safety Incident Investigations (PSII) will be scheduled for review of action progression at the IOP three months post report approval, regardless of expected completion date of individual actions.

The Trust has taken the issues identified by the Learned Coroner very seriously and has taken positive action to address those issues.

I would be happy to meet you to discuss this response if that would be helpful.

Yours sincerely,

,
Chief Executive