NHS
Royal Free London
NHS Foundation Trust

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Phone: [redacted]

Private and Confidential
His Majesty's Assistant Coroner Mr Ian Potter
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Via Email

28 January 2025

Dear Sir,

Re: Regulation 28: Prevention of Future Deaths report – Mnayea ZMF Al Basman (date of death: 25th March 2024)

We write to you in response to the Regulation 28: Prevention of Future Deaths report following the Inquest into the death of Mnayea ZMF Al Basman.

We would like to reiterate our sincere condolences to the family of Mr Al Basman for their loss.

The Royal Free London NHS Foundation Trust has carefully considered the matters of concern raised in the Regulation 28 Report. We note that the two consultants involved in the case (a colorectal surgeon and a renal physician) submitted written statements and gave evidence at the inquest but the Trust was not joined as an interested person to the inquest proceedings. We are grateful for the opportunity to respond to the matters you have raised. We would like to start by assuring you that the Trust had undertaken 3 safety review meetings as part of our routine governance processes before the inquest. These had identified areas of learning and included information that may have assisted you in relation to the areas of concern listed in this report.

You raised several matters of concern and we respond to each of them below:

> *"1) The consultant colorectal surgeon was not in the hospital over the weekend of 23/24 March 2024; however, he was able to be contacted if the need arose. The consultant surgeon noted the following matters in relation to the care provided to Mr Al Basman over that weekend: a further CT scan could have been indicated, particularly given issues with Mr Al Basman's drain, albeit there was nothing to indicate that any scan was needed on an urgent basis…"*

The patient was being treated for intra-abdominal sepsis with intravenous antibiotics and was showing steady improvement in the infection markers throughout the day prior to cardiac arrest. He had been reviewed that day by a consultant renal physician who examined him and discussed his care with the consultant colorectal surgeon in a phone call. The patient had

also undergone 2 prior CT scans on the 16th and 17th March, both of which showed no evidence of anastomotic rupture.

The case was reviewed at the Royal Free Hospital Patient Safety Response panel on 10th April 2024. A Learning from Death Review was presented and discussed at the Colorectal Mortality and Morbidity Meeting on 7 June 2024, followed by a presentation at the Royal Free Hospital's Mortality Review Group. The internal reviews concluded that an urgent CT at the time of deterioration would not have significantly impacted on the patient's ultimate outcome.

There are well-established arrangements in place that should emergency surgery be required, the on-call surgical team at Royal Free would have taken responsibility for the patient.

> *"...some entries in the clinical notes appeared falsely reassuring..."*

A foul-smelling discharge was noted at the surgical drain removal site. The resident medical officer reviewed the patient and administered further antibiotics. The consultant colorectal surgeon was not contacted but on subsequent review has stated that further CT scanning would not have been indicated overnight.

As part of ongoing education for junior medical and ward nursing teams, we will emphasise the critical importance of contacting the responsible consultant should there be any change in a patient's condition.

> *"...the physiotherapist who saw Mr Al Basman on the morning of 24 March 2024, noted that he appeared to be 'declining' but there was no evidence that this was escalated this to someone within the healthcare team..."*

Therapy teams often use the term "declining" or its variations to indicate a patient's unwillingness to participate in therapy, rather than a description of a deteriorating medical condition. On the day in question, the physiotherapist did not assess Mr Al Basman as the patient declined treatment. However, the physiotherapist did note that Mr Al Basman appeared more unwell, but there is no documentation confirming that this observation was communicated to the nursing or medical team.

To ensure appropriate identification and escalation of deteriorating patients, the PPU therapy team will participate in training on 'Management of a Deteriorating Patient'.

> *"...there was a degree of insufficient professional curiosity on the part of some clinicians who saw Mr Al Basman..."*

Medical documentation indicated that the patient experienced mild chest distress and abdominal distension, suggesting a potential for deterioration. In view of this, a plan is in place to ensure the PPU medical and nursing staff complete 'Management of a Deteriorating Patient' training. This training includes a review of recognising early signs of changes in the patient condition, methodology for clinical assessment and management, and a review of the framework to communicate concerns.

> *"...there should have been a plan in place overnight to more closely watch Mr Al-Basman overnight on 24/25th March..."*

A review of the medical notes acknowledges that while the patient's observations on the evening of 24 March 2024 did not initially raise significant concern, the reduction in urine

output in a dialysis-dependant renal patient would not have necessarily been an important marker of clinical deterioration. However, as part of an overall clinical assessment, deterioration in urine output should have been acknowledged and may have prompted an earlier medical review and closer monitoring.

While this may not have changed the ultimate outcome for the patient, it would have constituted best practice. As a result, an action plan has been implemented to support nursing and medical teams in identifying and appropriately responding to early signs of deterioration.

> *"2) Based on the above, the consultant surgeon formed the view that Mr Al Basman's clinical presentation should have led to the consultant being informed and consulted, but it did not."*

We acknowledge that the patient's condition appeared to deteriorate in the evening of 24th March 2024 and that closer monitoring and escalation to the consultant surgeon could have been implemented. However, three separate internal multi-disciplinary reviews concluded that there was no clear indication for an overnight– CT scan and that it was highly unlikely to have changed the course of the patient's management even if it had been performed.

> *"3) A number of the notes/records in relation to the care provided to Mr Al Basman, particularly over the weekend of 23/24 March 2024, lacked detail"*

We acknowledge that the documentation over the weekend of 23 – 24th March 2024 regarding discussions concerning the patient's condition could have been more thorough. This is reflected in an action plan for nursing and medical staff to improve assessment and documentation of potentially deteriorating patients.

> *Given that the events preceding Mr Al Basman's death have not been the subject of an internal investigation, I received little, if any, reassurance that these matters have been addressed.*

The Trust is committed to fully cooperating with all coronial investigations and keeps its processes for doing so under continual review. We hope this letter reassures you that Mr Al Basman's death was investigated and presented at the Royal Free Hospital's Patient Safety Event Review Panel (PSERP), a Learning from Death (LfD) review was conducted and presented at the Colorectal Mortality & Morbidity meeting and was also presented at the Royal Free Hospital's Mortality Review Group (MRG) prior to the inquest. Additionally, there has been a careful review of his care again as a result of your report.

The Trust is committed to learning from Mr Al Basman's tragic death and continuously improving patient safety. We will actively monitor adherence to the ongoing improvement plans and the Trust's action plan is set out below. This will be monitored by the PPU Divisional Quality & Safety Board and the Clinical Performance and Patient Safety Committee.

Action ID	Concerns raised	Action / Response	Owner	Action Deadline	Evidence if necessary
1.	Failure to escalate to consultant	• Education to Nursing and Resident Medical Officer (RMO) teams regarding how and when to escalate to consultant • Shared learning in divisional and consultant meetings • Review PPU Escalation Process	PPU Medical & Nursing Leads	June 2025	Training and audit log of education programme Presentation at divisional meeting
2.	Recognition of deteriorating patient	• Education programme to Nursing, Therapies and Resident Medical Officer teams to include: o Simulation training run by Royal Free Patient at Risk Team (PAART) medical and nursing staff in the management of a deteriorating patient o Revision on the importance and accuracy of fluid balance with clear escalation policy o Reiterate process of identification patients at risk of deterioration and process for escalation of care to HDU/ITU	PPU Medical & Nursing Leads	June 2025	Training and audit log Policy on deteriorating patient
3.	Documentation	• Education to nursing regarding clearly documenting conversation with doctor including what items were discussed and the plan • Reiterate Standardised template clinical workflow • Develop Documentation quick guide for staff reference	PPU Nursing Lead	June 2025	Training and audit log Documentation quick guide

4.	Seven-day services review/ doctor coverage plan	• Reiterate of out-of-hours / sickness cover for consultants • Reiterate of the responsibilities of primary admitting doctor speciality	PPU Medical Lead	June 2025	Presentation at PPU medical advisory committee
5.	Communication	• Create written standardised process of board rounds which will help with early identification of deteriorating patients • Review of consultant – RMO communication in and out of hours.	PPU Medical & Nursing Leads	June 2025	Standardised Board Rounds Document Documentation of education on consultant-RMO communication

We will be sending a copy of this letter to North Central London Integrated Care Board.

If you would like any further information about any part of this letter, please do not hesitate to contact us.

Yours sincerely,

[redacted]

Chief Executive Officer,
Royal Free Hospital
Royal Free London Group NHS Trust

[redacted]

Medical Director
Royal Free Hospital
Royal Free London Group NHS Trust