Royal Devon and Exeter NHS
NHS Foundation Trust

PRIVATE & CONFIDENTIAL
Dr Elizabeth Earland
HM Senior Coroner for the County of Devon
Exeter & Greater Devon Coroner's Office
Room 226, Devon County Hall
Topsham Road
Exeter EX2 4QD

Royal Devon and Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

Tel: 01392 411611

Your Ref: EAE/DMT File No: 243/2012

Our Ref: AMP/SW W2337SW/CEM/ss

CHIEF EXECUTIVE'S OFFICE
Direct Dial: [redacted]
Direct Fax: [redacted]
Email: [redacted]

Please direct all enquiries to [redacted] Trust Solicitor

29 May 2014

Dear Dr Earland

RECEIVED - 3 JUN 2014

Charles Ward Deceased
Inquest 25 March 2014
Coroner's Rule 28 Report

Thank you for your letter dated 14 April received on 16 April 2014 enclosing a copy of your Rule 28 report. I note you had requested a response in section 7 of your report by 2 June 2014.

I note the concerns identified during the course of the Inquest those being; non-contemporaneous record keeping and failure to record and deliver up all the medical records to the Coroner and disposal of the nasogastric tube in question making your investigation much more difficult.

I am pleased to note that you received the SIRI report and action plan relating to this incident showing that all actions were complete. I will therefore not forward another copy with my letter as I understand this already forms part of your file.

I also understand that you were provided with the Trust's current Nasogastric Tube Policy during the course of the Inquest.

I was sorry to hear that on this occasion, no contemporaneous note was made by the staff nurse in question involved in this patient's care during the shift when the patient became unwell. [redacted] the staff nurse in question who gave evidence at the Inquest, has been reminded that contemporaneous record keeping is necessary at all times. He is aware of the confusion and difficulties this caused to your service, the pathology service and the police. I understand that Staff Nurse [redacted] made a detailed record when he next came back on shift 24 hours later but this did not immediately find its way to the original notes which were by then with the pathology service. I apologise on behalf of the Trust for this error. I understand that Staff Nurse [redacted] in his evidence at the Inquest did reflect on this and apologised for this error and understands the consequences this has caused.

[redacted]

The requirement for contemporaneous record keeping is given a high profile within the Trust. Following feedback from the Care Quality Commission and the Trust's own review processes, our staff accept, understand and recognise the importance of excellent documentation. Improved documentation can be directly linked to the quality care for our patients. Our work around "Understanding Care" will have a focus on care planning, which is how we document the care our patients should receive and how this enables improved communication between professionals and with the patient and family. "Understanding Care" is a key work stream of the Trust's Nursing & Midwifery Strategy. Each year a work stream is created and this year it is documentation.

We are using our Care Quality Assessment Tool (CQAT) process, to ensure that documentation is given a higher priority in scoring. Case notes are audited through various review processes to ensure compliance with standards and remains a very high priority within the Trust.

In relation to the disposal of the nasogastric tube in question, I understand that as this patient did not die immediately following the discovery of this incident, the NG tube was not retained in this particular case. Mr Ward was having ongoing care in ICU and when it became apparent that the NG tube itself was not faulty, it was not retained. In retrospect, it would have been helpful and appropriate for this tube to have been retained.

In the latest incident reporting policy, I understand that this will be more explicit in relation to retaining equipment and devices. Awareness will be raised within the Trust in relation to these issues.

I am very sorry that this death occurred and the Trust has taken this matter very seriously and learnt lessons from these failings.

I hope this additional information will reassure you that sufficient and satisfactory steps have been taken to ensure contemporaneous record keeping and full records being forwarded to you are in place. In addition, when to retain equipment and devices is being reviewed as an ongoing process. If I can provide you with any further information, please do not hesitate to contact me.

Yours sincerely

[redacted]

Angela Pedder OBE
CHIEF EXECUTIVE

CC: [redacted] Trust Solicitor

[redacted]