Barts Health NHS

NHS Trust

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Ref: SR756

8 July 2014

Coroner ME Hassell
Senior Coroner Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

By special delivery

Dear Madam

Inquest Touching the Death of Gregg O'Reilly

I write in response to your Regulation 28: Report to Prevent Future Deaths received on 20 May 2014.

I can inform you that investigation into your concerns regarding the opportunity missed by medical, ward nursing and critical care outreach teams, to refer Mr O'Reilly to critical care, as well as the absence of a record of observations between midnight and on 17 January 2014 and 0300 hours on 18 January 2014, when he was on two hourly observations, and was found to have suffered a second bleed with very low blood pressure, for which a cardiac arrest call was made, has now been concluded.

I am satisfied that this investigation has been sufficiently robust, in that we have scrutinised all relevant records and interviewed staff to inform our investigation. I write to apprise you of the conclusions to the investigation.

During the investigation, senior medical and nursing staff have investigated the concerns raised in your report as well as the wider issues which impacted upon Mr O'Reilly's death.

The key recommendations of the investigation are set out below.

1. The Trust Executive Team to consider the wider learning points from this review and instigate changes as appropriate.

2. The relevant ward to have a Band 7 Sister recruited as a matter of urgency given the overall acuity of this ward and the need for senior leadership locally.

3. Ensure the transition period from a paper based system to the full electronic patient record is as short as possible and ensure the risks of the hybrid system are on the Risk Register and appropriate mitigation is in place.

4. Explore the usage of an electronic patient record red flag to identify chronically ill patients who have complex care needs and require frequent admissions to hospital. This would involve the key contacts from the multi-professional teams being incorporated into this system to expedite care and ensure continuity for the patient and the family.

5. The Critical Care Outreach Team (CCOT) and the consultant intensivists to develop formal guidelines, outlining when CCOT should request a critical care medical review.

6. Chronically sick patients who are causing concern should have a "Case Review Meeting" which should involve all relevant teams involved in the care to agree and implement the overall management plan.

7. Managing the Acutely Ill Patient Group (MAIPG) to be revamped, by expanding the membership, ensuring greater participation of senior clinicians from all Clinical Academic Groups, setting clear objectives with timelines, to address the most important issues. This group has forged strategic links with the Trust Quality Group and the new Mortality Review Board to ensure greater executive awareness and support. Strengthening the links between MAIPG and the Care Quality Collaborative – Deteriorating Patient Group.

8. In line with the Berwick Report 2013 the MAIPG to have a patient or public representative to sit on the forum to voice concerns and challenge decision making to improve patient safety.

9. Ensure each clinical team conducts a Morbidity and Mortality review, ideally using an agreed Trust proforma for all patients who die in hospital. Any suspected preventable death identified to be escalated to the Mortality Group and a Serious Incident proforma raised.

10. Launch an Education Strategy to ensure all staff can identify a sick and deteriorating patient and can escalate concerns. The Trust medical and nursing Induction Programmes to incorporate a briefing on 'Recognising and Responding to the Deteriorating Patient.'

11. The Trust is planning an "all site" Cardiac Arrest Call Audit in July 2014 to determine what factors pre-empted the call and to look at whether appropriate care was taking place prior to the arrest. Ensure the findings are widely disseminated, action plans agreed, and all key groups mentioned above are involved in delivering the key recommendations.

12. The Trust to re-establish the Critical Care Board, as a matter of urgency. The Terms of Reference, membership and Chair have now been agreed and a provisional date set of August 2014 has been set for the first meeting.

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We have taken this as an opportunity to review our processes to enhance future care. The outcome of the investigation will be shared with all relevant Trust medical and nursing staff to ensure that these changes are put into practice. The effectiveness of the changes will be subject to regular audit.

Thank you kindly for bringing your concerns to my attention. I trust you are assured I have taken them seriously and investigated them appropriately.

Yours faithfully

Medical Director
Barts Health NHS Trust