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County Durham and Darlington
NHS Foundation Trust

Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington, DL3 6HX
e-mail: [redacted]

Our Ref: SJ/bc/HMCoroner

26th May 2015

H.M. Coroners Office
PO Box 282
Bishop Auckland
Co Durham
DL14 4FY

Dear Sir,

I am writing to confirm safe receipt of your letter dated 30 March 2015. I am responding to the content of your letter and specifically those issues mentioned within your report under Regulation 28 of the Coroners Investigations Regulations 2013. The **Matters of Concern** as you stated:

"Although considered to be medically fit at 19:25 hours she did not leave the department until 23:03 and during that time she was not subject to any form of structured monitoring or observation although nursing staff may have seen her during that time. Evidence was given that since this incident staff have been reminded that patients should be subject to formal observations if there is a delay in discharge. Although I was told this I am unclear as to whether there is a formal trust policy in place in this regard".

"The deceased did not leave the department until 23:03. Evidence was given that it is common for patients to be discharged late on a night either home or to a care home knowing that there is likely to be nursing care available. The evidence that I heard is that there was no formal trust policy or written guidance with regard to the issue of late at night discharge and what other factors need to be taken account of in considering whether it is safe to discharge a patient at such time and in what circumstances. The evidence was that each senior doctor will apply his or her own medical discretion and combined with the pressures on a busy department I am concerned that this could lead to inconsistent or potentially erroneous decisions being made".

The issue you have raised was discussed at the Emergency Department senior staff meeting at the University Hospital North Durham which convened on 23 April 2015 and was subsequently discussed and agreed by the Emergency Department at Darlington Memorial Hospital. The consensus of opinion was that at the time of leaving the department it would have been sensible for a member of the team to have undertaken a set of observations on the patient, to act upon these if necessary as per the Early Warning Score (EWS) protocol and then to record these in the allotted field on Symphony (the Emergency Department electronic notes system). In addition there is also a field in Symphony, under the transport Data Entry Protocol (DEP), which the team member is able to utilise to record the name of the person to whom the patient is returning. Recording this information in the transport DEP will ensure that the Emergency Department team member has evidence that there is (when necessary) a responsible adult at the patient's residence who can take responsibility for the patient's safety and wellbeing.

This change in practice will be implemented immediately. Amendments have also been made to the Trusts 'Going Home Policy' (POL/NG/0005A), to reflect the discharge procedure from the Emergency Department including discharges after 22.00 hours. This was discussed and approved at the Trust's Executive Clinical Lead meeting on 21st May 2015 and will be discussed at the Quality and Healthcare Governance meeting in June 2015. The change in practice will be implemented immediately and audited as part of the routine Symphony records audit in which three sets of notes are audited daily for completeness.

These changes will be implemented across both Darlington and Durham Emergency Departments following approval.

Yours sincerely

DEPUTY CHIEF EXECUTIVE / EXECUTIVE DIRECTOR OF OPERATIONS

www.cddft.nhs.uk
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