University Hospitals of North Midlands NHS

NHS Trust

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STRICTLY PRIVATE & CONFIDENTIAL
Mr I S Smith
H M Coroner
Coroner's Chambers
547 Hartshill Road
Stoke on Trent
Staffs
ST4 6HF

Dear Mr Smith

Stephen RICHARDSON

Further to my letter dated 25 August 2015, I am pleased to provide a response to your report under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Mrs Stephen Richardson.

Background

The deceased was born with Downs Syndrome and he had experienced learning difficulties all his life. After his mother's death he became a resident in care homes. He walked with a gait as a result of a previous hip replacement operation, otherwise his mobility was good. He had not been prone to falls prior to November 2014. On 19 November 2014 the deceased complained to the care team of a painful right leg, indicating that he had banged it. Later that day, he was taken to the Emergency Department at the Royal Stoke University Hospital, Stoke on Trent. An x-ray revealed soft tissue injury but there was no fracture evident. On 17 December 2014 the deceased had been found on the floor in the hallway at the care home. He was thought to have suffered another fall but could not explain what had happened. Advice was sought from the NHS Help Line and he was given analgesia. On 21 December 2014 the staff at the home became concerned about a possible hip injury. The deceased was taken again to the University Hospital where he was diagnosed with abdominal distension probably due to constipation and he was discharged. On 24 December 2014, he was discovered with fresh bruising to his hip and thigh. He was taken once again to the University Hospital where a fractured pelvis was diagnosed. He was admitted. The fracture was treated conservatively. He developed a chest infection. He was discharged on 7 January 2015 but he was not well. On 8 January 2015 he was readmitted to the University Hospital with a temperature. His condition deteriorated and he died in hospital on 16 January 2015 at 1.20am.

Concerns

During the course of the inquest you felt that evidence revealed matters giving rise for concern. I note that in your opinion, there is a risk of future deaths unless action is taken. The matters of concern have been highlighted as follows:

1. Two professional carers drew to your attention concerns which arose on ward 225 at the Royal Stoke University Hospital. Care was needed with what the deceased took orally; his food needed to be softened and drink had to be given via a normal cup or glass. He had Downs Syndrome and did not know better himself. He was, despite notices above his bed, fed chocolate biscuits, pastry, baked beans and other solid foods all of which he might have aspirated. Drinks were often given in Tippee cups or in a glass with a straw both of which were inappropriate and again could have caused aspiration. Four copies of 'traffic light' notes were handed in to avoid this type of problem and the carers, when visiting, consistently had to reinforce these messages to nursing staff. It is unlikely that he did aspirate but he might have done. You expressed that it was depressing to note the frequent lack of care and attention to detail and therefore requested a report from the Ward Manager as to the issues raised.

HM Coroner reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Action Taken
The University Hospitals of North Midlands NHS Trust has taken the issues highlighted by the Coroner in his statutory report seriously. It is noted that no Trust members were called to provide a report to assist the Coroner in his enquiries and in this regard, Sr Shaw, Ward Sister for 225, has taken the opportunity to review the deceased's medical records to assist with this response.

Mr Richardson was initially admitted to Ward 226 on the 24th December 2014 but was subsequently transferred over to Ward 225 a few days later. On admission there were no signs of erratic breathing, rendering it difficult for Mr Richards to suck informally from a straw. This suggest that he did not receive too much liquid leading to a cough; if this had been the case, the nursing staff would have made an immediate referral to the SALT (Speech and Language Therapy) Team, as per Trust protocol.

It is clear from the medical records that the admission nurse was aware of the Traffic Light notes kindly shared by the Care Home staff and these instructions were immediately written above Mr Richardson's bedside. The instructions were that he should receive thickened fluids and an easy chew diet; this was therefore visible for all staff and it would be expected that this would be adhered to.

Sr Shaw works on the ward from Monday to Friday, and clearly remembers Mr Richardson. She recalls that he was always well presented, sitting in an upright position and that the staff became fond of him whilst he was under their care. Sr Shaw recalls a visit from Mr Richardson's Social Worker who reported that she could see how affectionate the staff had become towards Mr Richardson, and in fact because he was not having daily visits from his carers, the staff bought him Coca Cola, his favourite drink. The Social Worker did not report any concerns regarding his care.

Throughout the nursing documentation nutritional assessments were completed and it is clearly documented there were no concerns in this regard. Whilst it is difficult to provide a comprehensive response in regard to the comment that Mr Richardson was provided baked beans, Sr Shaw has sought a view from her staff and none are able to recall him receiving baked beans as part of his diet. Sr Shaw and the staff rely on the catering staff to provide appropriate meals for an easy chew diet and she is of the understanding that baked beans do not usually form part of this diet so it would be unusual for them to be served.

On occasions, Mr Richardson would become anxious and distressed which resulted in him throwing things (including soiled incontinence pads) across his room and it is for this reason that he was provided with Tippee Cups. There is often a fine balance when assessing patients' abilities to eat and drink independently and the nursing staff incorporate such assessments into the daily activities. It is documented that staff assisted Mr Richardson with his oral intake and again, if there were signs that he was having difficulties, a referral would have been made to the SALT team.

Sr Shaw is saddened that the Care Home staff felt that Mr Richardson was not cared for appropriately when there is evidence in the nursing records to suggest that nursing staff clearly took into account Stephen's needs and indeed, went beyond what is expected to ensure that his time on the ward was not too traumatic. The ward staff often develop a close relationship with Care Home staff so that care can be optimised, however in this instance, this did not happen due to limited visits from the staff at the Care Home. Sr Shaw is aware that the ward does not have a nurse 'champion' for those patients attending with learning disability and this is something that the Ward will look to implement in the future.

I sincerely hope that this report provides you with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising out of the inquest touching upon the death of Stephen Richardson seriously. It also concerns me greatly to hear that we potentially could have failed in caring for a vulnerable adult although, as mentioned above, we do have Trust representatives with a keen interest in protecting this vulnerable group of patients and I accept that we have to work closely with our community colleagues.

The Trust strives to provide a high standard of care to all patients and especially those who are considered to be vulnerable. I am grateful to you for raising these matters on this occasion and should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

Mark Hackett.

MARK HACKETT
CHIEF EXECUTIVE