Walsall Healthcare NHS
NHS Trust

Our Ref:
Your Ref:

Date: 08 January 2016

Patient Safety Department
Manor Hospital
Moat Road
Walsall
West Midlands
WS2 9PS

Mr Z Siddique
HM Coroner's Office
Crocketts Lane
Smethwick
B66 3BS

Tel: 01922 721172 ext 7481/7482/7354
Email: [redacted]
Website: www.walsallhealthcare.nhs.uk

Dear Mr Siddique

Re: Frank Mellers deceased
Date of Birth: 18th September 1921
Date of Death: 17th September 2015
Date of Inquest: 17th November 2015

I am writing in response to your report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

I would like to assure you that as a result of the Inquest findings, Mr Mellers' case was formally reported and investigated as a Serious Incident. As an organisation we have formal processes for investigating Serious Incidents. To this end, a Root Cause Analysis was completed which included a review of the systems in place for maintaining safety at the time. The learning from both the Inquest and the internal investigation will be shared with staff across the organisation.

Summary of Incident

Mr Mellers arrived via the Emergency Department on 14th September 2015 following a mechanical fall at home. As a result of this fall, Mr Mellers was identified as having sustained a fracture to the left neck of femur for which he underwent a hemi-arthroplasty procedure. Pre operatively, a Do Not Attempt Cardio Pulmonary Resuscitation (DNAR) document had been completed and discussed with Mr Mellers following concerns raised about the effect anesthesia during surgery would have. A telephone call was made to Mr Mellers' Grand Daughter to inform her of the risks associated with the surgery.

Mr Mellers surgery was carried out on 16 September 2015 and is noted to have progressed well with no immediate concerns noted. Mr Mellers was identified to be recovering well and returned to the ward the same day. Through the night, Mr Mellers is noted to have reducing blood pressure, oxygen saturation and temperature for which interventions were put in place to support him, Mr Mellers is recorded as appearing comfortable and reporting no increase in pain at that time.

On 17 September 2015, a call was made for the cardiac arrest team to attend to Mr Mellers; they did this and were able to regain pulse. However, following this, Mr Mellers experienced a second arrest and a decision was made to abandon the resuscitation as the team realised that there was a DNAR in place. Mr Mellers was recorded as dying at 12:20hrs.

Cont'd.....

Coroner's Concerns

During the course of the inquest the evidence revealed matters giving rise to concern. In the Coroner's opinion there is a risk that future deaths will occur unless action is taken.

The **MATTERS OF CONCERN** are as follows. –

1. Evidence emerging from the inquest suggested that the patients DNAR status was fixed without any reference to/discussion with his family. It is recognised that this is a medical decision for the physician but good practice guidelines require that the family be kept up to date with all such decisions.

2. There was generally poor communication between nursing and medical staff as evidenced during the inquest when a decision was made to attempt resuscitation despite there being a DNAR in place.

3. In light of the inquest findings, you may consider that the guidelines and policy in the issuing and communication of DNAR may need to be examined.

Action Taken

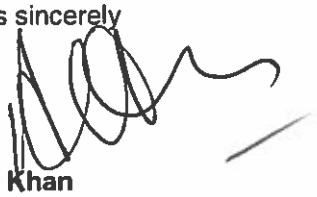
A Root Cause Analysis was undertaken following Mr Mellers Inquest and action has been taken with regard to communication with patient's families and between nursing and medical teams about DNAR.

The following actions have been taken:

- We have reiterated the importance of the use of our ward round standard which emphasises the importance of daily ward rounds to be carried out between both staff groups to ensure strong and robust care management.
- We have developed an indicator on our Ward Boards to ensure that where a patient has a DNAR in place it is highlighted to all staff. The Ward Boards act as a communication tool to allow for fast reference by all staff groups during handovers and during the course of the day.
- We reviewed our policy to ensure that it is compliant with best practice (including communication) with regard to DNAR.
- We have developed a leaflet to provide patients and families with information about DNAR (enc).
- The findings of Mr Mellers Inquest have been shared with relevant staff, including all Consultants.
- We have undertaken over the past several months a series of peer audits throughout a variety of care settings to review the effectiveness with which DNAR forms are being utilised. I am pleased to report that during this period we have seen significant improvements in the quality, completeness and robustness of the use of DNAR with particular emphasis placed upon ensuring discussions with patients and their families are clear and fully documented about the purpose and potential outcome of a DNAR. We will be carrying out these audits and reviews on a rolling basis to assure that the learning from this incident which we have disseminated across our organisation.

Finally, may we take this opportunity to offer our unreserved apologies to Mr Mellers family along with our sincere condolences for their loss.

Yours sincerely



Amir Khan
Medical Director