Basildon and Thurrock University Hospitals NHS
NHS Foundation Trust

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Mrs Caroline Beasley-Murray
Her Majesty's Coroner
HM Coroner's Court
A Block – Ground Floor
Country Hall
Victoria Road
Chelmsford
CM1 1QH

9 February 2015

Dear Mrs Beasley-Murray

Report to Prevent Future Deaths (Regulation 28) in the case of Mr John Charles Leyin

Further to your letter dated 16th December 2014, in which you provided a Report to Prevent Future Deaths, I have reviewed the content and the points that you have raised as matters of concern, in which you consider further action should be taken.

Following Mr Leyin's death in July 2013 an investigation was undertaken to explore the circumstances leading to this event and evidenced specific issues relating to care delivery. An associated action plan was developed to ensure that rapid and robust work was undertaken to ensure that a similar incident did not happen again at the Trust. In addition, work was already underway to change the manner in which Trust policies and procedures were cascaded across the Trust. I understand that [redacted] Nutritional Nurse Specialist provided evidence of this to the Inquest. Thereby I have outlined the detail of these actions alongside the concerns as you have raised them in the hope that these will reassure you that the Trust has already sought to address these issues.

1. **There was a failure on the part of the hospital to ensure the dissemination of Trust Policy and NPSA Guidance to all staff.**

   Since 2013 there has been an overhaul of the way in which NPSA Alerts and guidance are disseminated to Trust Staff. The Trust has appointed a Risk and Document Control Manager, who works within the central Clinical Governance Team. As part of their role they have oversight of all NPSA and other alerts, in addition to a role providing oversight of document control, related to Corporate and Clinical policies. It was evident that the process for disseminating clinical guidelines was fragmented. This process has now been standardised to ensure that any change to clinical practice is identified centrally and that this is cascaded to all clinical Divisions. Furthermore, a new system for the management of cascading patient safety alerts is under development, which will evidence action taken by Divisions, so that any non-compliance is addressed quickly and efficiently.

2. **There were weaknesses in the training systems in place.**

   The training system was reviewed as a result of this incident and weaknesses noted. The whole system and way the NG competence training was undertaken was strengthened.
   a. Only Nutrition Nurse Specialists to deliver theory training.
   b. Only designated NG Assessors are allowed to assess competence. The list of assessors kept by the Nutrition Nurses.

c. NG Competence divided into 3 parts 1) theory training 2) Part 1 (allowing nurses to manage patients with nasogastric tube feeding, verify tip position and administer feed and medication) 3) Part 2 (Place NG feeding tube)

d. All competency training records, once completed, are sent to the Nutrition Nurses for verification, then training record compliance is sent to Staff Learning and Development to add to their individual staff record

e. Monthly NG competence compliance circulated by Staff Learning and Development to Heads of Nursing and Senior Ward Sisters (and Nutrition Nurses)

3. **Checks were not made as to whether staff were up to date in their training for carrying out procedures such as the insertion of a nasogastric tube.**

   It was clear following the incident that additional checks were required to ensure compliance with training. As the manager responsible for the team the onus is on the Senior Ward Sisters to maintain their records locally. However, the monthly competence compliance report is circulated to the Heads of Nursing and Senior Ward Sisters as a fall back mechanism and enables them to keep track of their staff records as well. Paper copies of the nurses' Competency Framework are kept in staff records on the ward.

4. **At any one time there seemed to be a lack of knowledge as to how many trained staff were on duty to carry out such procedures.**

   I hope I have responded fully this specific point through the answers provided to questions 2 and 3.

I hope that this has provided you with sufficient assurance that we have undertaken a series of actions to mitigate any risk of a similar incident happening again. Further assurance can be provided through training records that are held locally at the Trust.

Yours sincerely

Clare Panniker
Chief Executive