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Private and Confidential

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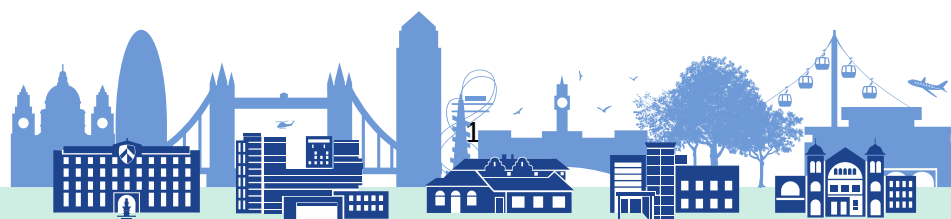
Dear Dr Julian Morris

Mr Harold Chapman came under the care of the Heart Hospital (University College London Healthcare Trust) in 2009 following a diagnosis of hypertrophic cardiomyopathy. Following the merger of the Heart Hospital with Barts Health Trust cardiac services in 2015 his care was transferred to Barts Heart Centre.

The Inherited Diseases service at Barts Heart Centre (BHC) manages up to 10,000 outpatient episodes per year and manages elective and emergency inpatients. The team includes a core group of 6 consultants, 5 clinical nurse specialists, 2 genetic counsellors, and 3 dedicated clinical fellows along with variable numbers of research fellows and training SpRs. Each week, the team complete more than 40 clinics, of which half are face-face with the consultant.

At diagnosis, Mr Chapman's condition was assessed as low risk, and this situation remained through to 2015 when he was first seen at BHC. At this time his test results, along with his clinical symptoms, indicated an increase in risk that should have led to referral for an Implantable Cardiac Defibrillator (ICD) but this was not recognised by the clinicians involved in his care. In April 2016 his risk was formally assessed and he was referred to the multi-disciplinary team meeting for consideration of ICD implantation. There was a considerable backlog with the MDT at that time, the waiting list for discussion was 2-3 months. Mr Chapman made efforts to chase the team, mainly through email correspondence with the clinical nurse specialist, to gain a conclusion as to his need for an ICD but he sadly suffered a sudden cardiac death in June 2016 before the matter was concluded.

A serious incident was reported by BHC following confirmation of the cause of Mr Chapman's death. An investigation was led by Dr Saidi Mohiddin, a consultant with the inherited diseases team but not personally involved with Mr Chapman's care. The investigation concluded that the root cause of Mr Chapman's death was the failure to recognise and action the risk factors for SCD presented by the patient in 2015. At this time there were established guidelines for the assessment of the risk of sudden cardiac death, however there was no mandated local policy for use of a formal risk assessment tool.



The service has taken action following the conclusion of the investigation to improve practice. This has included development of a procedural document detailing requirements for SCD risk assessment and pathways for escalation to the MDT meeting; adherence to this document is being monitored via the audit process. The MDT now meets twice weekly and the backlog has been cleared. The pathway document defines the acceptable interval between risk detection and presentation to MDT.

A complaint was received from Mr Chapman's widow in August 2016. This letter raised her serious concern with regards to the timeliness of care provided to her husband, insufficient risk assessment and lack of responsiveness when her husband was attempting to expedite his treatment. The site upheld Mrs Chapman's complaint and offered a full apology.

Following conclusion of Mr Chapman's inquest in 2017, a request was received from his family to meet with the staff at BHC. This meeting, chaired by Edward Rowland, BHC Medical Director, was held on 22/11/2017. The team were able to offer the family assurance that lessons had been learnt from Mr Chapman's death and practice had changed.

One of the lessons learnt from the investigation of this incident was the need to ensure that email correspondence with patients must be added to the patient's health record. The cardiomyopathy service has taken action to ensure that this is now done.

More widely, clear guidance is needed for all clinicians on their responsibilities regarding email communication with patients. Trust wide guidelines are being drawn up, working to the following principles:

1. Emails sent to and from Barts Health clinicians from other clinicians and/or patients which contain clinically important information about Barts Health patients, must be filed in the patient case notes.
2. If Barts Health staff give an email address to patients, then that email box must be monitored and all e-mails should be seen and appropriately addressed, within a clinically acceptable time period. If such an email address is temporarily not monitored due to leave etc, then the out of office message should make this clear.
3. The Barts Health website will be reviewed to ensure that patients and referrers know how to contact the hospital. If email addresses are published, it will be made explicit when and if the address should be used for clinical correspondence.
4. Letters sent to patients and clinicians will routinely detail how the clinical team can and should be contacted.

Yours sincerely



Dr Alistair Chesser
Chief Medical Officer

