NHS
Epsom and St Helier
University Hospitals
NHS Trust

Ms Karen Henderson
Assistant Coroner
HM Coroner's Court for Woking

Chief Executive's Office
St Helier Hospital
Wrythe Lane
Carshalton
Surrey SM5 1AA

Tel: [redacted]
Web: www.epsom-sthelier.nhs.uk
[redacted]

5 September 2018

Dear Ms Henderson

Rita Taylor (Deceased)
Response to Regulation 28 Report to Prevent Future Deaths

This letter comprises the formal response of Epsom and St Helier University Hospitals NHS Trust 'the Trust' to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 12 July 2018, 'the Report', made subsequent to the inquest into the death of Rita Taylor.

A copy of this letter will also be shared with the family of Mrs Taylor, to whom the Trust would like to express our deepest sympathy and condolences.

Background

Mrs Rita Taylor was admitted to Epsom General Hospital on 31st July 2017 from 'The Meadows', a mental health unit, following a collapse. She had a history of hypopituitarism requiring hormone replacement with desmopressin and steroids. On arrival to the Emergency Department (ED) she was confused but fully conscious and had normal blood pressure and breathing. Blood tests revealed profound hyponatraemia and moderate hypokalaemia. Over the next four days Mrs Taylor's desmopressin was withheld and her sodium levels rose too quickly and too high and she developed osmotic demyelination syndrome (central pontine myelinolysis) which resulted in brain damage and death.

The death was reported to the coroner and a post mortem was performed which gave the medical cause of death as:

1a. Pneumonia

1b. Central Pontine Myelinolysis

The following narrative conclusion was delivered at the inquest:

'Mrs Taylor died as a result of sub-optimal care contributed to by neglect.'

The Report raises the following concerns:

1. The failure to appropriately manage Mrs Taylor's hyponatraemia by the on call consultant physician on the 31st July 2017 on the grounds that it was not his sphere of expertise. No contact was considered or made to someone who may have been able to assist leaving Mrs Taylor to languish overnight with no management plan in place and a lack of any meaningful documentation in her hospital notes.

2. The failure, at any time between the 31st July and 5th August 2017 to follow the national recommended guidelines for the management and treatment of hyponatraemia, in particular the need to measure serum sodium regularly and to limit the rate of rise of serum sodium to prevent complications.

3. The failure, at any time between the 31st July until the 6th August 2017 to create a coherent plan for the management of Mrs Taylor's medical problems resulting in the failure to assess fluid balance or to reintroduce desmopressin, given a known diagnosis of diabetes insipidus on a background of a pituitary adenoma.

4. The apparent lack of understanding of the appropriate management of hyponatraemia by consultants whose care Mrs Taylor was under, despite two emergency consultant physicians having a specialist interest in endocrinology. Whilst some attempt was made to contact St George's hospital this was not successfully followed through to assist them in their management.

5. The failure of an emergency consultant physician with an interest in endocrinology to understand that giving intravenous fluids with potassium is not an appropriate method to increase serum potassium levels, more so as Mrs Taylor at that time could eat and drink normally.

6. The documentation throughout Mrs Taylor's admission until transfer to the high dependency unit was inadequate with no record of assessment or a coherent management plan in place to ensure appropriate care and continuity of that care for succeeding physicians to consider or to follow.

7. As was acknowledged in Court, the SI report did not fulfil its obligations and it was agreed that it would be extensively rewritten and re-presented to HM Coroner's Court to more accurately reflect the circumstances of Mrs Taylor's death and the learning points required to assist in preventing any future deaths.

The Trust's response to the concerns set out in the Report

We summarise your concerns and the actions being taken forward to address them as follows:

1. **Concerns 1, 2 and 4** – There was an apparent lack of understanding of the appropriate management of hyponatraemia among the Acute Medical Unit 'AMU' consultants who treated Mrs Taylor.

   Response - The Trust has moved the handbook of medical emergencies, which includes guidance on the management of hyponatraemia, to the Trust intranet, which can be more easily accessed by staff. (See Recommendation 1 of the Action Plan). This was completed in August 2018.

   Recommendation 2 of the Action Plan confirms the guidance on the management of hyponatraemia will be updated and relaunched. The guidance has been updated and is currently going through the approval process with the Medicines Management Committee which is made up of clinical representatives across the hospital. The Trust's Communication Team will share the updated guidance with all clinical staff and appropriate education around the updated guidance will be arranged.

2. **Concern 3** – There was a lack of a management plan for the treatment and monitoring of patients with hyponatraemia.

   Response - The AMU lead within the Trust is devising a new pro - forma for the documentation of monitoring plans for patients. Recommendation 6 of the RCA report specifies the need for the monitoring plan for patients with hyponatraemia to set out the desired rate of rise of that patient's sodium and the risks associated with a rise steeper than this. The monitoring plan will also set out when to consider restarting medication such as desmopressin.
   The Trust has also set up a Task and Finish Group to review the feasibility of cohorting patients needing the highest acuity of care, (which would include those patients who need regular blood tests), with the ambition that these patients are placed in a specialist ward area from April 2019 to facilitate more regular reviews of their management. Care View, an electronic handover system which allows high risk patients and their management plans to be communicated more effectively is also to be introduced to AMU.

   There has also been a review of the work patterns of Consultants working on the Acute Medical Unit and the Trust now requires AMU Consultants to work on AMU on at least two consecutive days in order to improve the continuity of care for AMU patients.

   Recommendation 3 of the RCA report also sets out that the Trust will be ensuring that adherence to the policy for the Management of the Acutely Ill Patient is monitored at the divisional Morbidity and Mortality meetings.

3. **Concerns 3 and 5** - There was a failure to assess Mrs Taylor's fluid balance and to understand that prescribing intra venous fluids with potassium is not an appropriate method to increase serum potassium levels.

   Response - The updated guidance on the management of hyponatraemia will set out the importance of ensuring that patients with hyponatraemia have regular monitoring of their fluid balance charts.

   The Trust has also set up a Task and Finish Group to review the process for managing the fluid balance charts of all patients in the Trust and a programme of training will be introduced following this review - see Recommendation 7 of the Action Plan.

4. **Concern 3** – There was a failure to reintroduce desmopressin for Mrs Taylor.

   Response - Recommendation 5 of the Action Plan sets out that; '*Desmopressin should be notified as a high risk drug that should not be discontinued without specialist advice.*' The specialist providing the advice to discontinue the drug will ensure that there is a plan in place to reintroduce the drug at an appropriate time. This action has been implemented by the Medicines Management Committee with input from the pharmacy department.

5. **Concern 6** – There was a lack of documentation to ensure continuity of the patient's care.

   Response - The Trust is reviewing how we monitor compliance with our Health Record Content policy which outlines the record keeping standards for Trust staff. There are 14 standards set out within this policy which have been taken from the guidance provided by the Royal College of Physicians. There will be a twice annual audit of the 14 standards set out within the policy which will include an assessment of the requirement to include '*clear evidence of the arrangements made for future and ongoing care'.* The Joint Medical Director and Deputy Chief Executive has also circulated a copy of the concerns raised in the Report to Prevent Future Deaths to all consultants within the Trust and has reminded them of their accountabilities around the documentation of management plans and reminded them of the standards for documentation set by the Royal College of Physicians.

6. **Concern 7** – The Serious Incident Report did not fulfil its obligations and it was agreed that a supplemental report would be prepared to reflect the circumstances of Mrs Taylor's death and the learning points required to assist in preventing any future deaths.

   Response - [redacted] Associate Medical Director and Responsible Officer, gave evidence in court that the Trust would be reviewing the concerns raised during the inquest process and that we would be preparing a supplemental Root Cause Analysis 'RCA' report to address these concerns. A copy of the supplemental RCA report is enclosed and we hope that you agree that the actions and recommendations set out within the Action Plan of this report address the concerns raised within your Report to Prevent Future Deaths.

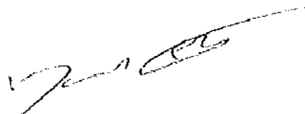
In order to support the sharing of learning from this incident the Joint Medical Director and Deputy Chief Executive has presented the case at the Epsom Hospital Grand Round meeting where she highlighted the learning and reflections from both the internal investigation and the concerns raised in your Report to Prevent Future Deaths. In addition, as detailed above
the Joint Medical Director and Deputy Chief Executive has also circulated a copy of the concerns raised in the Report to Prevent Future Deaths and the Trust response to all consultants within the Trust.

All of the clinicians who gave evidence at the inquest hearing have also reflected on the conclusions of the Serious Incident investigation and have discussed the learning and recommendations from the Root Cause Analysis investigation reports with the author of the RCA who is also the Associate Medical Director.

I hope that this letter has provided you with assurance that your concerns have been taken very seriously by the Trust and that our procedures and processes have been revised to address those concerns.

We will share this letter with the family of Mrs Taylor and hope that it provides them with some reassurance that the Trust now has systems and processes in place to ensure that all patients with hyponatraemia will have a clear treatment plan to correct their sodium in line with recognised guidance and that any risk of over rapid correction of hyponatraemia will be avoided.

Yours sincerely,



Daniel Elkeles

Chief Executive
Epsom and St Helier University Hospitals NHS Trust