NHS
University Hospitals
of North Midlands
NHS Trust

Trust Ref: INQ/101/19

18 December 2019

Royal Stoke University Hospital
Executive Suite
Springfield
Newcastle Road
Stoke-on-Trent
Staffordshire
ST4 6QG

Tel: 01782 676612
[redacted]

Mr A Barkley
H M Coroner
Coroner's Chambers
547 Hartshill Road
Stoke on Trent
ST4 6HF

Dear Mr Barkley

Julie MORREY

Further to previous correspondence, 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 Julie Morrey.

Recorded Circumstances of the Death
The deceased passed away in the Royal Stoke University Hospital on 10 January 2019 having admitted herself there on 7 January 2019. She had a number of pre-existing medical conditions, the most significant of which was a transplanted kidney which she has had since 2016. Believing that she was suffering with a chest infection, she visited her GP on 4 January 2019 but self-presented to ED on 7 January 2019 where she was recognised as suffering from renal failure and bronchopneumonia. Despite timely review by a renal specialist, she was not provided with adequate fluids for over 24 hours by which time her condition had worsened and despite admission to the ICU she deteriorated and died.

Concerns
During the course of the inquest H M Coroner felt that evidence revealed matters giving rise for concern. In his opinion, there is a risk that future deaths will occur unless action is taken. The matters of concern are as follows:

1. There was a clear lack of communication between the hospital departments as to which department was responsible for the patient after she was assessed by a renal specialist and a plan made for her care and whilst she awaited a bed on the Renal Unit during which time she was looked after on AMU. During this time she was without fluids for over 24 hours.

2. There was a clear failure by nursing staff to pro-actively manage her condition due to a lack of policy, procedure and professional responsibility to the patient.

3. There was no review of the patient by a senior clinician for about 24 hours following her admission and whilst she awaited a bed on the Renal Unit.

Action Taken
Following the inquest, the Trust has reviewed matters raised by H M Coroner and the following response outlines the Trusts' position in respect of each of the concerns above.

1. The "Renal pathway for patients referred for admission from ED/AMU" has been agreed, which includes detailed advice about clarifying the reason for referral. Trust Internal Professional Standards have been amended with the support of the Medical Director to enhance fitness for purpose and to prevent recurrence of patient care failing due to misunderstanding between departments.

2. Emergency Department (ED) actions
    a. The Coroners verdict has been discussed with the senior Nursing Team (17 December 2019) and will be shared within the Department setting in the monthly, quality newsletter (December edition).
    b. Any patient who requires speciality care is now escalated and discussed within ED huddles and the discussion is documented in the Huddle Log.
    c. The senior Matron is now assured that patients requiring speciality input are identified in clinical areas. A daily review is undertaken by Matron/Deputy Matron or Senior Sister.
    d. There is increased staffing of senior nurses in ED and 2 senior nurses are now allocated on a planned duty rota.
    e. There has been a workforce realignment to ensure all patients are assigned a registered nurse.
    f. Reflective statements will be obtained from those involved in the deceased's care.

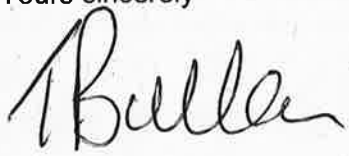
    AMU actions
    a. A review of AMU admission documentation has been undertaken. The AMU admission document will identify that medical management has been enacted.
    b. There is to be an escalation of care to the Nurse in Charge and/or senior decision maker in circumstances where no management plan has been enacted. This is to be recorded in the nursing documentation and through completion of Datix.

3. Clinical teams would like to reassure H M Coroner that both Renal and Acute medicine do have robust mechanisms for ensuring senior review of patients. In this case, if either specialty had thought the patient to be under their care, they would have had a review. On this occasion, the lack of a consultant review was not a separate or additional error; it all stems from the misunderstanding of allocation at the beginning of the patient's care. The corrective actions outlined in 1 and 2 above will prevent such a situation from arising in the future.

I sincerely hope that this report provides H M Coroner with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising from the inquest touching upon the death of Julie Morrey seriously. The Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these concerns on this occasion.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely



Tracy Bullock
CHIEF EXECUTIVE