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Barts Health
NHS Trust

22 February 2021

Trust Executive Office
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[redacted]

www.bartshealth.nhs.uk

Mr Graeme Irvine
HM Area Coroner for East London
Walthamstow Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Dear Mr Irvine

Re: Inquest touching upon the death of Mrs Evadney Dawkins

I write regarding your letter of 21 December 2020 regarding your concerns relating to the death of Evadney Dawkins at Newham University Hospital. Barts Health NHS Trust has learnt lessons following this case, and is confident the changes implemented and planned will significantly minimise the risk of a recurrence.

I will respond to your concerns in turn.

On 22nd July 2018, Mrs Dawkins was assessed to require renal monitoring, incorporating;

a) **Regular blood tests**
b) **A renal ultrasound**
c) **Fluid intake/output monitoring**
The 3 actions were not undertaken for 4 days, after which, it was discovered that the patient had deteriorated and had sustained a Grade 3 acute kidney injury.

There have been many changes to address poor handover and lack of knowledge around AKI on the site. Management of AKI is a key component of the Foundations of Excellence program of nursing education which has been rolled out to all areas However, it was acknowledged that further work needed to be done with the nursing staff to ensure that nurses were sufficiently able to recognise and monitor a renal patient to a high standard. To this end, a second site safety nurse role has been established with a particular remit of nursing education, with a focus on deteriorating patients.

The hospital undertakes frequent audits on nursing documentation, which includes fluid balance, and on NEWS2 for deteriorating patients to gain assurance that care is of a good standard and any deficiencies are addressed. In terms of medical training, recognition and treatment of deteriorating patients is very much the focus of our compulsory simulation days for Foundation and Core Medical trainees. The AKI bundle has been implemented on the site which standardises the response to a patient with AKI and which actions and escalation should be taken following identification. This will

include a supported database so that all patients with AKI can be monitored and compliance can be likewise be monitored.

Since moving to electronic records system in Autumn 2019 the process for documenting and completing patient records is more accessible and easier to manage, as information is recorded in the same place and legibility is guaranteed. For example, in relation to fluid management charts, input/output can be automatically entered on to the electronic records system, rather than having to rely on paper based charts, contained within the records. This system generates alerts when safe parameters are breached.

Regarding nursing handover, standardised ward handover templates have been developed and are in use. In terms of handover for doctors, these are now run by the most senior doctor present; they happen daily and there is a dedicated room for them to happen to avoid disturbances. Support for daily Consultant ward rounds has been agreed; recruitment to these posts is in process.
There is also a huddle meeting in the operations hub each morning which gives an opportunity to hand over patients of particular concern. Furthermore we have undertaken simulation training with the whole MDT to improve communication.

The Trust's governance systems did not assess to a case as a Serious Incident requiring investigation for 2 years.

We recognise that there was a failure to assess and grade Mrs Dawkins's death correctly as a Serious Incident at the time it happened. We now have an established and robust system in place where unexpected deaths are taken to a Serious Incident Review meeting where they are considered by a multidisciplinary team. Where there is doubt, the hospital errs on the side of declaring the incident as a Serious Incident and investigating as such, de-escalating as appropriate.

Additionally we have appointed three Medical Examiners who review every death on the site. These roles are overseen by the Deputy Medical Director which is an additional new post, part of the remit of which is to give greater assurance around patient safety governance. In this way, deaths that do not meet the criteria for a Serious Incident are robustly reviewed. We believe that had these actions been in place at the time of the incident, it is highly likely that it would have been declared as a Serious Incident.

Thank you for bringing this to my attention and I hope that I have been able to reassure you in showing that we are actively working to ensure measures are in place, and are followed, to reduce this risk.

Yours sincerely

[redacted]

Dr [redacted]
Group Chief Medical Officer
Barts Health NHS Trust