PHOENIX HOSPITAL GROUP

Ms ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

30 April 2021

Dear Ms Hassell

Prevention of future deaths report following the inquest into the death of Paula Anne SPEIRS (died 28 August 2020)

I refer to the above Prevention of Future Death Report.

We were greatly saddened by the death of Ms Speirs following her respiratory arrest and transfer out from The Weymouth Street Hospital ('The Weymouth') on 25 August 2020. I can confirm that this matter has been discussed with the Care Quality Commission (CQC) and we have provided full details of our actions taken including supporting documentation to the CQC. We would like to again offer our sincerest condolences to the family for their loss.

As set out in our Serious Incident Review (SIR) and as noted at the Inquest, Ms Speirs arrived at The Weymouth at approximately 7.05 am on 25 August 2020 for an elective surgical procedure. The decision was taken not to proceed with her surgery by [redacted], Consultant Plastic Surgeon and Dr [redacted], Consultant Anaesthetist. No formal admission pathway was initiated for Ms Speirs however Ms Speirs was shown to an individual ward room (room 301). A full set of observations were carried out in the room by the HCA and reported to the registered nurse. Ms Speirs requested to freshen up in the room's en-suite facilities and was subsequently assessed by [redacted], Dr [redacted] and the nurses.

Whilst Ms Speirs was awaiting collection by her husband she rested with the bedroom door left open, allowing her to be observed by our Ward Manager, [redacted] (a registered nurse of 36 years' experience) and [redacted] (a registered nurse of 20 years' experience). [redacted] was the registered nurse on duty for the third floor on the day in question. [redacted] maintained visual observations, including a regular review of her sleeping position.

Although she was drowsy, Ms Speirs roused easily to voice and responded to questions (indicating Glasgow Coma Scale of 13-14). She moved herself into the recovery position when requested by staff and was also observed by the Resident Medical Officer (RMO).

Ms Speirs was in the hospital under visual observations for approximately four hours before she was found unresponsive. [redacted] immediately initiated the pathway for cardiopulmonary resuscitation. Appropriate resuscitation efforts were made by Weymouth Street Hospital staff after Ms Speirs suffered a respiratory and cardiac arrest. Ms Speirs subsequently required to be transferred out to University College London Hospital (UCLH) for further treatment and monitoring.

In your Prevention of Future Death Report, you highlighted the following points and I will address each in turn in this letter: -

1. The fact that no formal observations were ordered or undertaken, including ensuring that a nominated individual was tasked with monitoring her. No instruction was given on how frequent she should be checked or the nature of that review;

2. The nurses looking after Ms Speirs were not given any instructions on how to avoid positional asphyxia and when the Coroner asked regarding this risk, the nurses had not previously heard of positional asphyxia.

Response regarding formal observations for patients

Ms Speirs' attendance to The Weymouth was exceptional in that she did not initiate any of the hospital's formal admission pathways. Indeed, strictly she was not admitted, merely allowed to use a room until collected. Ms Speirs was planned to be admitted as a surgical patient, however as the decision to cancel the procedure was made soon after arrival formal documentation was not commenced as it normally would be.

[redacted], who was the lead Consultant responsible for her care, and Dr [redacted], as her anaesthetist, examined her in the patient room and both undertook a lengthy consultation. Upon arrival to her room, a set of formal observations were conducted and documented in the patient's notes. The nurses and RMO maintained visual observations for the duration of Ms Speirs stay.

It is recognised that The Weymouth's processes and protocols should be reviewed and addressed in the light of this incident and the Coroner's findings.

I have broken down the steps taken as follows: -

1. Audit

I enclose a copy of an audit of the records of formal observations of patients at The Weymouth between January and March 2021. As you will see, this identifies that of 100 patients, 95 were the subject to formal and regular assessment. Of the 5 remaining, 3 patients initiated our outpatient pathway as outpatient 'Walk in Walk out' patients who do not require formal observation. One patient was a sleep study which followed a specific pathway, and the final exception was a patient whose procedure was cancelled. This patient's procedure was cancelled on the day due to having a fever identified in reception.

During the Covid pandemic, The Weymouth has operated a 'Green Pathway' ensuring that all patients isolate as per NICE guidelines, have a Covid-19 PCR swab performed 72 hours prior to admission and have a temperature reading taken on admission which must be within normal ranges. This ensures safety of the patients undergoing anaesthetics, other patients within the hospital and The Weymouth team.

As the above patient presented with a fever, she failed the Covid screening even though she appeared well, and the operation was subsequently cancelled. This patient was using NHS transport to get to and from the hospital. For the safety of staff and patients, the decision was made to isolate the patient and therefore move them to an individual ward room. The patient had to wait 2 hours for NHS transport to arrive. In this time the patient was offered food and their temperature was rechecked. No formal observations were conducted or documented. The observation policy, in conjunction with the admission policy and departmental teaching, has modified operational procedures such that, moving forward, this patient would have had a full set of observations conducted and documented throughout their attendance at The Weymouth even though this does not occur routinely at other private or NHS hospitals. This information would then be passed on by the consultant to the patient's GP for follow up post-departure.

Please refer to the audit report attached for a full summary of conclusions.

It is our intention to re-audit on a quarterly basis to ensure our policy results in formal observations on all patients even if not having treatment.

2. Policies and Protocols

I enclose a copy of a revised admission policy. The Weymouth has been unusual in having robust universal pre-assessment for many years; each patient undergoes formal assessment and the assessment is sent to the anaesthetist asking if further tests or interventions are required. The pre-assessment nurses are supervised by another consultant anaesthetist and follow a number of pre-set pathways for hypertension, diabetes etc that follow the latest national guidelines. In the light of this case we have now mandated that a formal response must be received from the anaesthetist even when no further pre-assessment intervention is required. It also sets out reasons for non-admission with a comprehensive list of conditions that are unable to be admitted due to safety. In addition, this has now been amended to make it clear that patients are deemed 'admitted' from point of signature on the registration form in reception even if never having formal admittance documentation completed. This ensures that all staff are aware of their duty of care towards all patients whilst present at The Weymouth. This policy also states that patients that appear visibly intoxicated cannot proceed with their planned procedure.

I enclose a copy of the ward observations, reporting and escalation policy which now formally states that all surgical and medical patients within The Weymouth will be observed at no less than 4-hour intervals from admission to discharge. It clearly outlines the documents which are present in specific locations that can be initiated by staff, such as neurological observations charts and the UK NEWS2 Charts which were already in use. The observation policy details the expectations that all clinical staff are required to follow regarding observation documentation including clear responsibilities amongst clinical staff.

I also enclose a formal care plan which has now been implemented and is to be in place for any non-surgical patient including cancellations of surgery or medical admissions. This is to be completed by the admitting Consultant. It clearly specifies the expectation from the Consultant on frequency of observation and a clear discharge pathway.

We have also established a policy for the management of a suspected intoxicated patient, a copy of which is attached. This policy gives guidance on the management of a patient who attends in a state that appears intoxicated, including suspected or known, accidental or intentional overdose or poisoning of a known or unknown substance. The protocol includes conducting a rapid bedside toxicology saliva screen to detect and confirm the presence of cannabis, cocaine, opiates, amphetamines, benzodiazepines, methamphetamines and alcohol. This policy ensures the early identification of a suspected intoxicated patient, appropriate escalation, ongoing monitoring, clinical intervention, and process for escalation to facilities beyond The Weymouth's capabilities. The policy ensures holistic and thorough management and considers safeguarding. Education on this new policy, as well as ongoing simulations, has been undertaken for all Weymouth staff (and indeed all staff across Phoenix Hospital Group).

The Transfer Out Policy, already comprehensive, has been further updated. A copy is attached. This policy gives guidance to Weymouth staff on ensuring that the patient who requires further support are transferred safely with minimal adverse events, in a timely manner by suitably trained staff to an appropriate facility. We now also mandate all patients who may develop an unsafe airway must be transferred to a more appropriate setting for their specific condition.

In addition, and for ease of reference, I enclose copies of our Major Haemorrhage Policy, Management of a Deteriorating Patient and Resuscitation Policy. We include these documents as they have had recent revisions and show our robust safety approach to emergency procedures.

3. Training

I enclose records of mandatory eLearning competencies completed by Weymouth Ward staff**.** This record details that compliance is regularly monitored by the Ward Manager, Human Resources, the Clinical Governance team and the Director of Operations. Any staff that have expired mandatory training are given time within their shift to complete it and given opportunities to request additional training if required. This record shows the extensive training and learning available to clinical staff via our online learning portal 'MyCloud'.

Moreover, I enclose a copy of further completed eLearning competencies via the online portal e-LfH, which has been made available to Phoenix Hospital Group by the NHS during the pandemic and going forward. These competencies are additional to the mandatory training and staff have been encouraged to take advantage of the access to eLearning via this platform.

I also enclose copies of internal facilitator reports following Middlesex University simulation training in March 2021 as well as a report from internal simulation training conducted by the Clinical Governance and Risk Leads. During this training, ward staff received education on the revised Massive Transfusion Policy, Transfer Out Policy, Observation Policy, Deteriorating Patient and Resuscitation Policy and Suspected Intoxicated Patient Policy.

In summary, all our staff are trained, given revision and tested in line with established hospital, including NHS, practice.

4. Review and Communication

I enclose a copy of the minutes of the Serious Incident Review Group lead by the Chairman of our Clinical Governance Committee, Medical Director, Responsible Officer and other Senior clinicians which reviewed the Coroner's findings.

I enclose minutes of the meeting of the Weymouth's Clinical Governance Management Meeting, Ward Nurses meeting and Clinical governance meeting with Weymouth Managers and their deputies, at which the relevant issues were highlighted and addressed.

Further, I attach minutes of the meeting with the staff nurses involved, and reflection and debrief, following the recommendations from the Prevention of Future Deaths report.

I also enclose the minutes of the ward meeting, confirming the discussion of Resuscitation, ILS, training and the identification and management of the deteriorating patient.

Finally, I attach a copy of the Communication to all Consultants admitting patients to the Weymouth emphasising their responsibility for patients at the Weymouth including for the pre-surgical period.

It should be noted that under our Practising Privileges agreement, responsibility for the care of the patient rests with the admitting consultant. I have met along with our Responsible Officer and Chairman of our Clinical Governance Committee with [redacted] and Dr [redacted] to review the learning and reflection by the Consultants in light of the Coroner's comments. I enclose a copy of the letters to [redacted] and Dr [redacted].

Response regarding Positional asphyxia

It was stated at the Inquest that none of the 4 witnesses was aware of the condition 'positional asphyxia'.

Despite comprehensive investigation we have failed to identify that this term is used or taught in training or clinical practice in healthcare in the UK, with the exception of environments where physical restraint or rapid tranquilisation are employed e.g. in police custody/ cells or in a mental health facility. It is true the four witnesses were unaware of the term, but that is neither unusual nor a matter for criticism.

It is our understanding that positional asphyxia is defined as occurring when a person is placed in a posture that prevents or impedes the mechanism of normal breathing. If the person cannot escape from the position, it can result in asphyxia. Typically a restraint would be the cause of the subject being unable to escape from the position e.g. pressure is applied to the back of the person held in the facedown prone position, or pressure is applied restricting the shoulder girdle or accessory muscles of respiration. There is no physical restraint, restrictive interventions or rapid tranquilisation used at the Weymouth Street Hospital.

In any event, The Resuscitation Council (UK), National Patient Safety Agency (NSPA), and NICE guidance suggests that even in any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used, there should be immediate access to staff trained in ILS and to appropriate ILS medication and equipment. Further to this, those who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in ILS.

The Weymouth is **not** a setting where restrictive interventions are used, nor are there any clinicians who deliver restrictive interventions so Weymouth staff, like other hospitals, do not actively train for it and it would be inappropriate to do so. All clinical staff are trained and attend annual refresher courses in ILS (Resus Council accredited) at Middlesex University covering all relevant aspects as determined by the professional trainers and the approved curriculum. Positional asphyxia is not included in any Resus Council accredited ILS training.

Positional asphyxia is simply not taught in the UK in an acute hospital setting. However, the knowledge and skills for management of the airway is taught, which includes appropriate use of the recovery position. It is important to note that Ms Speirs was placed in this position in line with Resuscitation Council guidelines. The knowledge and skills for management of the airway and positioning of a patient, is embedded in clinical care delivered at the Weymouth and throughout Phoenix Hospital Group.

To acknowledge our newly acquired knowledge regarding 'positional asphyxia', the learnings from this investigation have been disseminated with all clinical staff.

In support of and as evidence of the above I enclose a selection of documents as evidence:-

1. Please see enclosed a statement from Dr [redacted], Consultant Anaesthetist with significant experience and a note of a conversation with [redacted], Senior Lecturer and Head of the Clinical Skills department at Middlesex University, regarding the term positional asphyxia.

2. We also have enclosed an SOP from Kent Police highlighting the relevance of positional asphyxia in a custodial environment.

3. We wrote to the Resuscitation Council and the Royal College of Nursing to seek further guidance on the training in and the use of the term positional asphyxia and have included copies of our letters and the responses received.

As you will see, the Resuscitation Council UK advise that positional asphyxia is not a term that the Immediate Life Support (ILS) course would routinely use as it is not relevant to the clinical scenarios on the course.

The Resuscitation Council UK further advise that the Immediate Life Support (ILS) Course is primarily aimed at healthcare professionals who may act as the first responder in an emergency and teaches the skills to manage a deteriorating patient and initiate life support to patients who suffer a cardiac arrest. ILS candidates are healthcare professionals from a variety of backgrounds, and it is not possible to include all potential clinical scenarios. However, airway management is a core element of the course and causes of airway obstruction, recognition, and treatment of airway obstruction are all covered in the course manual and e-learning materials. Airway management skills are also assessed during hands on skill teaching sessions and throughout the scenario sessions. As confirmed above, all clinical staff at The Weymouth are trained and attend annual refresher courses in ILS.

A response was also received by the Royal College of Nursing advising that the Resuscitation Council UK are best placed to advise in this area as they are national experts and they set policy.

Further learning

Further simulation training conducted by the Clinical Governance and Risk leads has been undertaken for staff that were unable to attend the previous session. The simulation outcome report is attached. In addition, we are currently scheduling a Managing a Deteriorating Patient workshop to be conducted by Middlesex University for all ward clinical staff to attend.

Even though the nursing staff followed Resuscitation Council guidelines, we will also be highlighting the issues raised by the Coroner to our nurses through our regular weekly briefings.

Additionally we will be undertaking a final reflection and learning session into the Inquest, the current response to the CQC and Coroner and any other process improvements, which I will lead as Chief Executive.

Further action and next steps

I enclose a timeline setting out those steps still to be taken.

I enclose for ease of reference a schedule of supporting documents along with the relevant supporting documents.

Summary

Ms Speirs was an extremely sad and unusual death. Due to the unusual nature of her presentation, Ms Speirs did not initiate any of The Weymouth's formal admission pathways. Phoenix Hospital Group and particularly Weymouth Hospital staff have been greatly impacted by the events that occurred. The Weymouth has reviewed and revised many of our policies and procedures as well as implemented new ones where needed. Significant learning and reflection has occurred. However, within our reviews, we have also found many of our policies and procedures are robust and appropriate. Our audit and the enclosures demonstrate we do undertake observations and provide a safe environment**.** As a result, we believe we meet and in many instances now exceed the requirements set by policy in other NHS and private hospitals.

We will be sending a copy of this letter to our relevant contact at the Care Quality Commission.

We are committed to ensuring The Weymouth Street Hospital is the safest possible environment for patients and would be pleased to receive feedback or comments on any of the steps or points highlighted in this letter.

With best wishes.

Yours Sincerely

[redacted]
Chief Executive Officer
Phoenix Hospital Group