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NHS Foundation Trust
Patient Services and Quality Improvement
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Newcastle upon Tyne
NE27 0QJ
[redacted]

28 July 2021

Ms Carly Henley
HM Assistant Coroner for Newcastle upon Tyne
Lower Ground Floor
Block 1
Civic Centre
Barras Bridge
NE1 8QH

Dear Ms Henley

INQUEST INTO THE DEATH OF BENJAMIN CLARK
RESPONSE TO REGULATION 28 REPORT; PREVENT FUTURE DEATHS RESPONSE

We write in response to your Regulation 28 Report dated 8 July 2021 following your investigation into the death of Benjamin Clark. This response has been prepared by Northumbria Healthcare NHS Foundation Trust (The Trust) and addresses the concerns as set out by HM Assistant Coroner.

The Trust will respond to each of those concerns in turn.

Response

The Trust is committed to ensuring that lessons are learned when any serious incident occurs. At the time of the incident a Serious Incident (SI) Investigation was undertaken and the Trust formed an action plan. Both the SI investigation and action plan were shared with HM Senior Coroner in advance of the inquest.

During the inquest HM Assistant Coroner heard oral evidence from the Trust in relation to the measures and steps that have been implemented since this incident in order to reduce and mitigate the risk of any future incidents occurring.

Matters accepted during the inquest by the Trust

During the inquest the following was accepted by the Trust:

1. Mr Clark had been transferred to North Tyneside General Hospital (NTGH), ward 24, as a level 3 falls risk (requiring observations in line of sight). At the time of Mr Clark's fall, this had been reduced to a level 2 (observations every 30-60 minutes) however, observations undertaken had in fact been once every 2 hours.

2. The change from level 3 to level 2 had not been documented within the nursing records (as detailed in No.1 of HM Coroner's matters of concern).

3. There was evidence that the Avoiding Falls Level of Observation Assessment (AFLOAT) tool had been used however, this was not contained in the nursing documentation.

4. Nursing records in this matter were poor and not to the Trust expected standard.

5. At the time of the incident, staff were using a standard observation chart which did not stipulate timings for enhanced observations such as level 2 and above.

Evidence of change heard during the inquest

HM Assistant Coroner heard evidence from Matron [redacted] as to the extensive steps that the Trust have taken following this incident. Matron [redacted] confirmed the following:

1. Since the incident involving Mr Clark, the ward at NTGH have now implemented a new observation chart. This chart determines the frequency that observations should be taken on the front of the chart. The reverse of the chart is set out differently to the standard observations chart to allow for increased frequency observations to be completed. A copy of this observation chart was shared with the family and HM Assistant Coroner on the day of the inquest. It was confirmed that the use of this chart was a pilot and is well used within NSECH and had also been adopted by NTGH.

2. Safety huddles which take place on a daily basis discuss observations that are set for patients and include levels 2, 3 and 4 each morning.

3. Aside from the observations undertaken for Mr Clark, and the issues relating to frequency of observations as set out above, all appropriate risk assessments in relation to falls were completed for him in a timely way.

4. Discussions are ongoing between the Matrons within NTGH in order to place the AFLOAT risk assessment and observation chart onto the electronic care record NerveCentre. The Trust can confirm that this will be done before the end of August 2021. Notwithstanding this, the documents are in use in paper form.

5. Once the documentation is placed on NerveCentre, an electronic alert will be created for observations and will alert staff via a hand held electronic device that a particular patient observation is due, ensuring a more robust regime for observations. The level of observation set by a Registered Nurse is linked to the timed alert required for care rounding.

The Trust notes that concerns 1-3 within HM Assistant Coroner's PFD report addresses those concerns at the time of the incident but does not appear to take into account the extensive steps that the Trust spoke of during the inquest and that have already been put in place since this incident.

The Trust considers that the measures that have already been implemented alongside the ongoing discussions, have significantly reduced the risk of a similar incident occurring in future.

The Trust considers that in such circumstances, a PFD report is disproportionate and, in accordance with paragraph 10(3) of the Chief Coroner's Guidance No.5, a concern of a risk to life caused by present or future circumstances is no longer present.

Below is set out the response to each of HM Senior Coroner's concerns:

Concern 1

As indicated above, the Trust accepted that Mr Clark's observations were downgraded without any notes to justify this reassessment.

Paragraphs 1 and 2 of *'Evidence of change heard during the inquest'* confirms the measures implemented to ensure that observations are discussed within teams more frequently and the frequency of observations is clearly recorded within the patient record.

Concern 2

Paragraph 1, 4 and 5 of *'Evidence of change heard during the inquest'* confirms that a new observation sheet is already in use which will stipulate on the front, the level of observation assigned and the frequency of which those observations should be undertaken. The Trust is also planning to further enhance this system by implementing a system of electronic alerts to notify staff when an observation is due.

The Trust can confirm that the AFLOAT risk assessment and observation chart will be placed onto NerveCentre before the end of August 2021.

Concern 3

The evidence provided to HM Assistant Coroner was that the AFLOAT tool was used in both hospitals and the AFLOAT assessment is kept on the ward. The AFLOAT assessment is a laminated chart, kept on all wards, which staff refer to for setting a level of observation, prior to adding onto NerveCentre. The evidence heard was that the AFLOAT tool had not been included within Mr Clark's documentation. The evidence did not suggest that only NSECH used this tool in writing.

As per paragraph 4, AFLOAT is in use in paper form. The Trust can confirm that AFLOAT is used by all hospital sites within the Trust to assist with setting the level of observation. However, the final decision is at the nurse's professional judgement. The nurse should document their rationale if they do not agree with the AFLOAT recommendation.

Matron [redacted] explicitly confirmed that a new observation chart, as set out at paragraph 1 of the *'Evidence of change heard during the inquest'*, was already in use at NTGH as a pilot. The "Increased Care Rounding" paper chart is freely available and its use is encouraged when providing Level 2 observations. The Trust has not proceeded past the pilot stage because an electronic version is being created instead, held within NerveCentre.

The assessment is carried out daily or more frequently if there is a change in the patient's condition. AFLOAT assessment will be on NerveCentre and will alarm every 24 hours so there is a mandatory daily review. This needs to be completed by a Registered Nurse. At the end of the assessment, the nurse can either accept of decline the advised level of observation. If declining, they are mandated to provide rationale for their clinical judgement

AFLOAT does not convey a patient's falls risk (all patients over 65 years of age and those with a history of falls should be considered at risk and the Trust complies with this in its Falls Risk Assessment document). AFLOAT conveys the level of observation that a patient should receive to try and reduce their risk of falls. National Institute for Health and Care Excellence (NICE) and the Royal College of Physicians (RCP) are very clear that we should not use risk stratification tools.

We hope that the information provided during the inquest and in writing offers you the necessary assurances that the Trust already have in place effective measures, which they continue to review to develop and improve, to ensure that observations are appropriate and falls risks are mitigated.

Yours sincerely

[redacted]

Chief Executive