NHS
Royal Free London
NHS Foundation Trust

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[redacted]

Private and Confidential

Coroner ME Hassell
Senior Coroner
St. Pancras Coroner's Court
Camley Street
London N1C 4PP

Date: 14 October 2021
[redacted]

Dear Coroner Hassell

Re: Prevention of Future Deaths Report following inquest into the death of Stephen Walker (Date of death: 06/04/2021)

I am writing to you following my letter of 26 August 2021, in response to the matters of concern raised in your Regulation 28 Report: Prevention of Future Deaths, following the Inquest in to the death of Dr Stephen Walker.

In my letter of 26 August 2021, we confirmed that this case was presented to our Safety Incident Review Panel, and it was agreed to declare it as an externally reportable serious incident with our commissioners. The investigation has now concluded and the report has been submitted to our commissioners.

I attach a copy of the completed investigation for you, in Appendix 1, including the action plan and identified learning.

The investigation was led by a senior clinician, not associated with the service, or Dr Walker's care and treatment, and the investigating panel comprised a multidisciplinary team who were also not involved in the incident, and included staff experienced in root cause analysis investigation, human factor analysis and effective solution development.

We appreciate having the opportunity to review Dr Walker's care and treatment, which has allowed us to identify a number of learning points for our organisation around documentation, escalation, incident reporting and recording outcomes of Mortality and Morbidity meetings.

I would like to inform you that the Royal Free Hospital has recently launched a new electronic patient information system called EPR, which allows our clinical teams to have access to contemporaneous clinical records. We are confident that this will support improvements in both documentation and communication.

Doctors working in the service have also been asked to ensure that they always escalate the refusal of an NG tube to the Consultant on call.

In addition, we are currently reviewing our processes for recording outcomes of Mortality and Morbidity meetings, by actively exploring existing systems within the organisation.

In addition to commissioning the serious incident investigation, a learning from death review was also commissioned, and approved at our hospital Mortality Review Group on 8 October 2021, which we also include, in Appendix 2, for your information.

Following finalisation of the investigation, Dr Walker's wife will now be offered a copy of the final investigation report and will also be invited to attend a meeting with representatives of the Trust, to discuss the investigation findings and any learning for the Trust.

The final report, including the shared learning will also be shared with all staff involved in the incident, to facilitate learning and reflective practice. The learning from the incident will also be shared widely at the Service Line meeting, the Divisional Quality & Safety Board meeting, the Clinical Performance and Patient Safety meeting, as well as other relevant forums and newsletters.

I would again like to reassure you that we take any untoward death of a patient extremely seriously and would like to thank you for providing me with the opportunity to respond to this Regulation 28 Report.

Please let us know if you require any further information at this point.

Yours sincerely

[redacted]

Dr [redacted]
Chief Executive
Royal Free Hospital