21 April 2022

NHS
King's College Hospital
NHS Foundation Trust

**Private and Confidential**

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Dear Madam

I am writing to you in response to the regulation 28 report made following the inquest into the death of Martha Mills on the 25th February 2022. I would like to thank you for bringing your concerns to my attention. This is a truly saddening case, and one that I have been briefed on by the Chief Nurse regularly. I can only imagine how difficult this has been for Martha's family, and I am sure that they also welcome your intervention and insights in ensuring we learn from her death.

This has been an incredibly sad case, and one in which we have recognised from an early stage that there were things which we could and should have done differently to give Martha the best opportunity to recover from this injury. I am truly sorry for the mistakes that were made.

We had undertaken a serious incident investigation following Martha's death that identified a number of causal and contributory factors which we agreed needed to be addressed to improve safety. The action plan to address these was included in the Serious Incident investigation report which was shared during the inquest. I note that your report asks us to take further steps, so I have included an updated position in relation to the serious incident action plan in addition to outlining the steps to address your findings. This is to ensure that our proposed actions are understood in context, and also to offer you and Martha's family assurance that we are taking the steps which are needed to prevent this happening again.

**Serious Incident Finding 1**

- Sub-optimal interface between Paediatric Hepatology and Critical Care services.

| Action Proposed | Update |
|---|---|
| Establish regular meetings between Rays of Sunshine ward and other paediatric wards and PICU to review all referrals | A safety huddle has now been established which includes review of all referrals, lessons learnt and actions taken. This also supports |

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| between the services, lessons learnt, and actions taken | increased face to face contact between the paediatric wards. |
| Seek to fully fund a Paediatric Critical Care Outreach service to bring the paediatric service into alignment with adult critical services at KCH through submission of a business case | The business case for an outreach team has been written and submitted, and is due to be considered by the Trust's Investment Board in May 2022. |

The table set out above relate to the actions in the serious incident report. In your report you explained that:

*'You had heard evidence that the intention of King's to improve the formal relationship between the hepatology and the paediatric intensive care departments, and to ensure that there is pro-active paediatric intensive care outreach. However, the intended programme has stalled, I think partly because of the pandemic. It seems that there needs to be an impetus for this to be re-started and to gain sufficient momentum to operate smoothly in the future.'*

Therefore the additional actions have also been initiated:

- Following Martha's death it was agreed that the escalation process (previous version 2016) needed to be refined and formalised through a standardised operating protocol (SOP) for children requiring critical care. This includes the internal escalation pathway for children requiring critical care specifying when children should be escalated. This ensures that there is a standardised approach to escalation, rather than reliance on individual clinician decision making. Any member of the clinical team can refer to critical care for advice where a child meets the criteria recommended in the SOP. The SOP is currently being reviewed and signed off through the Child Health Governance processes and the current draft is enclosed. This is due to be approved in May 2022.
- A weekly group has been set up consisting of the Children's Health Senior Leadership Team, Site Medical Director, Director of Quality Governance and an Organisational Development expert to ensure that there is focus and momentum in implementing the action plans.
- An organisational development expert has been identified to work alongside the Children's Health Senior Leadership team to develop a bespoke package that will help to enhance effective clinical relationships between hepatology and the paediatric intensive care departments. The package consists of three stages which will help the teams to explore and build better relationships in relation to collaboration, communications and conflict.
- Improving the care of deteriorating patients, specifically including paediatric patients, has been agreed as one of the Trust's 4 Quality Priorities for 2022/23. This means that the improvement work will be subject to enhanced scrutiny at Executive and Non-Executive level to support momentum.

**Serious Incident Finding 2**

- High thresholds for Paediatric Critical Care review of children with evolving severe illness on ROSW

| Action Proposed | Update |
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| Review current VCH policy for escalation processes for junior medical staff and nursing staff | The escalation policy has been revised and finalised and is currently proceeding through governance sign off processes and is due to be signed off in May 2022. |
| Emphasise on the importance of parental concern as a trigger for early review by improving the education and training for the use of the parental concerns tool the BPEWS chart. | The wording of the parental concern trigger has now been agreed, and this is being incorporated into the electronic PEWS. |

The table set out above relates to the actions arising from the serious incident investigation. In your report you explained that:

*'I heard that the bedside paediatric early warning score (BPEWS) system at King's is currently still paper based, unlike the adult system. It was put to me very forcefully by medical staff that, until the PEWS system moves to an electronic base as part of electronic recording of the paediatric records as a whole, monitoring and care of children may be sub optimal, with a higher risk of this sort of situation recurring.'*

At the current time there is no nationally agreed early warning score for children as discussions involving the Royal College of Paediatrics and Child Health (RCPCH) and NHS England have yet to provide a consensus agreement on what form this should take. This means that the commercially available electronic PEWS systems are limited and therefore most hospitals depend largely on the customisation of in-house clinical IT systems according to the decision of the local teams. The Bedside PEWS (BPEWS) is the early warning system that the paediatric team at KCH have chosen to use in the absence of specific national direction on the matter.

The Trust has very recently committed to the implementation of a fully integrated electronic patient record system (Epic) which will replace the vast majority of existing clinical IT systems in late 2023 and will provide a customised early warning score for paediatrics. However as an interim measure, with support from our in-house clinical IT support teams, we have now developed a way of capturing paediatric early warning scores on our existing electronic system. This will support clinical teams to capture all relevant observations, highlight patients at risk (to those at the bedside and those monitoring the wards overall), and ensure that the team can document what has been done to treat/escalate based on the score.

**Serious Incident Finding 3 & 4**

- Insensitivity of BPEWS alone for identifying deteriorating children.

- Reliance upon systolic blood pressure as a marker of cardiovascular dysfunction in children

| Action Proposed | Update |
|---|---|
| Review current VCH policy for escalation processes for junior medical staff and nursing staff | The escalation policy has been revised and finalised and is currently proceeding through governance sign off processes and this is due to be signed off in May 2022. |
| Review and improve medical and nursing training on BPEWS, escalation and outreach. | Nurses and medical staff receive PEWs training on induction and nurse education team have been spot checking nursing staff assessment, documentation and action taken on observations. Where any gaps are identified in practice, a re-training package is put in place. PEWS training is also included in regular recall training. All student nurses receive training in PEWs each year including initial induction and then refresher sessions for each year of training.<br><br>The sepsis training has now been made mandatory for paediatric staff. The Health Education England module on paediatric sepsis is being integrated into the Trust's learning and education platform (LEAP) to ensure that training compliance can be monitored. It is anticipated that this will be completed by May 2022.<br><br>Deterioration Patient training (Deteriorating Child on the Ward – how, when an who to escalate?) is now included in the PICU teaching lecture attended by all child health trainees. This commenced in March 2022, and the session will be delivered biannually going forward (March and September each year).<br><br>Further training is being developed to support roll out of electronic PEWS, which include the parental concern trigger. The education team are part of the working group and will be supporting the roll out in June. |

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| Introduce scenario tool kit as mandatory for all child health NIC and junior doctor staff | STPN scenario tool kit is now mandatory for all child health nurse in charge and junior doctor staff. It is being incorporated into simulation days recommencing in May 2022 |

**Serious Incident Finding 5**

- Restricted medical process for escalation to critical care review.

| Action Proposed | Update |
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| Seek to fully fund a Paediatric Critical Care Outreach service to bring the paediatric service into alignment with adult critical services at KCH through submission of a business case | The business case for an outreach team has been written and submitted, and is due to be considered by the Trust's Investment Board in Q1 2022/23 |

**Serious Incident Finding 5**

- Complex underlying and incompletely characterised acute illness driving deterioration.

| Action Proposed | Update |
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| M&M case review | This was completed in October 2021 |
| Assign a 'Named Consultant' with overall responsibility for decision making and definitive communication in pancreatic trauma cases | Consultant of week for surgery and hepatology on the day of admission will have named joint responsibility for the patient. The clinical ownership will still change week to week with the consultant of the week, which is standard practice for all long term patients.<br>Regular weekly multi-disciplinary team (MDT) meetings are in place to ensure good communication and handover. |
| Development of patient and next-of kin information resources to support them through admission with pancreatic trauma | This work is in progress and is expected to conclude in summer 2022. |
| Develop an on-site paediatric echocardiography service:<br>- Formalise pathway for rapid escalation for paediatric echocardiography involving the Evelina and the on-site adult cardiology teams dependent upon age<br>- Train on-site technician service to undertake paediatric echocardiography and supplement the service from the Evelina | Meeting took place with Evelina hospital in April 2022 to progress paediatric cardiac service collaboration. This work is on course for completion by the end of 2022. |

**Monitoring of ongoing actions**

The Trust, and all of those involved in Martha's care, are very sorry for what has happened. We understand that there were failings in our systems and processes to protect Martha, and we are committed to ensuring that there is lasting organisational change as a result. To ensure that this is the case, the actions outlined in this document will be overseen in the following way:

- Regular task and finish group meetings to support action plan implementation
- There will be an audit of the escalation SOP at 3 months post implementation and then at agreed intervals. Results will be reported through to the Children and Young People's Board which is chaired by the Chief Nurse.
- The organisational development plan will be kept under review through oversight of outcomes at each stage.
- Update on overall progress against the defined actions will be monitored through the Serious Incident Committee, and overseen by the Patient Safety Committee which is chaired by the Medical Director.
- Assurance will be provided to the Quality, People and Performance Committee on the completion and impact of the actions taken, which is chaired by a Non-Executive Director.
- The Care Quality Commission will be updated regularly as part of relationship management meetings.

The Trust is always willing to provide Martha's family with regular updates on the progress that has been made.

Yours sincerely

[redacted]
**Chief Executive**