University Hospitals Birmingham
NHS Foundation Trust

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For the attention of Emma Brown
Area Coroner for Birmingham and Solihull
50 Newton Street
Birmingham
Sent by way of email only: birmingham.coroner@nhs.net

5th October 2020

Dear Ms Brown,

Inquest touching the death of Francis Xavier Cooney
Response to Regulation 28 Report to prevent future deaths

I write in response to the Regulation 28 Report made by you following the Inquest into the death of Mr Cooney, which concluded on 5 August 2020.

University Hospitals Birmingham NHS Foundation Trust (the Trust) has carefully considered the concerns raised within your report to prevent future deaths which surround the communication with relatives/carers of those with cognitive impairment where changes are made to medication.

Lasting Power of Attorney

Following Mr Cooney's admission on 9 January 2020 it was identified that he lacked capacity to consent to surgical intervention to repair a wound to his scalp, as he was unable to retain the information surrounding the risks and benefits of the procedure. Mr Cooney's daughter was present during the discussion and advised that she had lasting power of attorney (LPA). She agreed with the decision to proceed with surgery.

In accordance with our Mental Capacity and Best Interests Procedure and Guidance document, Mr Cooney's daughter should have been asked to provide a copy of the registered LPA for Health and Welfare so that this could be reviewed and a copy placed on Mr Cooney's records. Although it was documented that Mr Cooney's daughter held an LPA, a copy of the document was not requested. In the particular case of Mr Cooney, this would not have altered the decision making around the care that he received during this episode. Given that he had been assessed as lacking capacity, communication with the next of kin and/or carers regarding any changes in treatment were indicated whether an LPA was in place or not.

Changes to medication

During an in-patient stay clinical teams will discuss changes in medication with patients at the time of ward rounds, administration and at the times of other assessments. In the context of the in-patient stay of a person without capacity, then best interests decisions may be made without necessarily contacting the next of kin, for example in the initiation of antibiotics to treat infection. It is a clear expectation that any changes in medication prior to or on discharge will be communicated with the patient and / or their next of kin and / or their carer to ensure safe discharge.

Dr [redacted] was of the opinion that the small reduction in dose of the sedative medications, nitrazepam and amitryptiline, in the context of ongoing delirium, represented dose optimisation rather than a strategic change in medication. This is consistent with the measured concentrations of these drugs in the report from Dr [redacted] which were in the therapeutic range. There was no change in the dose of the anti-depressant citalopram, in which the concentrations measured by Dr [redacted] were also consistent with therapeutic levels.

Mr Cooney was admitted under the care of the plastic surgery team as a consequence of his scalp injury. He was reviewed during the admission by Consultant Geriatrician, Dr [redacted] because of concerns surrounding ongoing delirium. It is clear from the notes that her advice as to therapeutic changes of the above medication was acknowledged by the admitting team. In this context it would be expected that the discharging team (plastics) would discuss all discharge medication with the patient and / or their next of kin and / or their carer as appropriate. Whilst the decision to reduce the medication was discussed with Mr Cooney, and it was considered at the time that he had understood the information provided, in light of his fluctuating confusion, it is recognised that Mr Cooney's daughter should have been informed of the changes that had been made and unfortunately this did not happen and this is a matter of regret. We are satisfied that this was an unfortunate individual error and that there are processes in place to ensure discussion as to medications do take place appropriately on the discharge of patients.

Medications provided on discharge

I would not have expected the relatively small changes in medication to have led to Mr Cooney's distress in isolation but this is on the basis that I would have expected his medication on discharge to have been contained in a blister pack, as it was on admission. A blister pack contains separate sealed compartments for medications to be taken out at particular times of the day and this is of value for patients, such as Mr Cooney , with fluctuating levels of capacity.

However, as a consequence of our detailed review of Mr Cooney's last admission prompted by your letter; it has now been determined that unfortunately Mr Cooney was not discharged with his medication in a blister pack but in individual packs. This information is different to that provided by the nursing team, including in their evidence at the inquest. This was an error and we wholeheartedly apologise for the evidence before the Coroner being incorrect in this regard. It would appear that the nursing staff who provided this evidence had a genuine belief that Mr Cooney's medication was packaged in this way in light of the records, but it has emerged that this was an error, occurring within the pharmacy team.

This issue, i.e. the use of a blister pack, seems likely to be central to the subsequent sad events.
On admission on 9 January 2020 it was correctly noted by the ward pharmacist that Mr Cooney was receiving his medication in a blister pack. This is noted to ensure that there is consistency between admission and discharge so that the patient is discharged with an updated blister pack. Mr Cooney should have been discharged home with a blister pack, but this did not happen. It is most likely that this is the error that contributed to Mr Cooney becoming confused and distressed regarding the tablets he needed to take when at home.

A subsequent investigation by our Chief Pharmacist has identified that a note was made on the pharmacy system on 24 January that a blister pack was not required for Mr Cooney's take home medication. This seems to have been an error, as there is no documentation of the rationale for such a decision which would be expected to have been recorded in the

event of such a change. The pharmacist who made the entry cannot recall whether, or if so then how, a request to make this change was made.

This error seems then to have been compounded by the fact that a need for a blister pack was not appreciated by the nurses discharging him. Despite a clear icon, familiar to users (the B in front of the green cross in Figure 1 below), located in the banner (a part of the electronic record that is always visible to the user), this discrepancy seems to have been missed. At present, no individual can account for these errors, which arose in series, and that is very much a matter of regret. It is our intention to reinforce (as per below) the need for these medication issues, and the system prompts relevant to medication, to be a matter of additional focus for both pharmacy and nursing staff on discharge.

Action Plan

We apologise unreservedly to the Coroner and Mr Cooney's family that the evidence presented was inaccurate, but we are satisfied that this was a genuine error, which was in all probability influenced by the record indicating a need for blister packs.

The first issue that we have addressed is that the tragic events leading to Mr Cooney's suicide were not identified as requiring further internal investigation. We have implemented a system where any such event occurring within 28 days of discharge is identified to the Chief Medical Officer. In particular our legal team will work with a named Deputy Medical Director to review the circumstances of the last admission where the cause of death is identified as suicide. We anticipate that this will assist the Coroner and the family in their understanding of relevant events.

An action plan to address the failure to obtain a record/copy of the LPA is being developed. A communication from the Chief Medical Officer and Chief Nurse will be circulated, addressing the importance of the process to follow, which is set out within Trust policy, where an attorney has been appointed under a LPA for Health and Welfare and this will be completed within the next 4 weeks. In addition to the practical step of establishing a specific location for easy access to any LPA on the Clinical Portal component of our electronic healthcare record, we will be emphasising the importance of communication with both patient and family as appropriate. This is in addition to the refresher work being done across the Trust as to all aspects of the Mental Capacity Act and the protections afforded to patients without capacity, either permanent or fluctuating.

Secondly, a review of the process within our pharmacy team has taken place and we are satisfied that we have a robust electronic system to capture how medication should be provided to patients. A retrospective review of patients requiring a blister pack over the past 12 months has been carried out. There have been no similar incidents to the failure in regard to Mr Cooney's discharge blister pack, we are reasonably confident this was an isolated incident of human error.

Nevertheless, in light of this incident, our Chief Pharmacist has taken a number of steps to reduce the possibility of a similar incident occurring in the future. An email was forwarded to our pharmacy team (covering all 4 sites) on 18 September 2020 sharing the learning from this case and reinforcing and reminding staff of the current processes that should be followed and that any clinical interventions or proposals, notable clinical conversations or decisions, must be documented.

Having considered the concerns raised within your report, and the matters identified regarding an apparent failure of the discharge process, we have put in place a number of other actions to reduce the risk of a similar incident arising in the future.

We will be undertaking a refresh of training across all wards on the importance of

1. Review of medications on discharge with the patient
2. Communication of medications on discharge with the next of kin and / or their carer at the point of discharge
3. The importance of ensuring that the requirement for a blister pack is both recorded and actioned

Finally, I will communicate with the medical staff reinforcing the importance of communication with relatives and carers where patients have a cognitive impairment and the learning from this case will be cascaded through departmental clinical governance meetings.

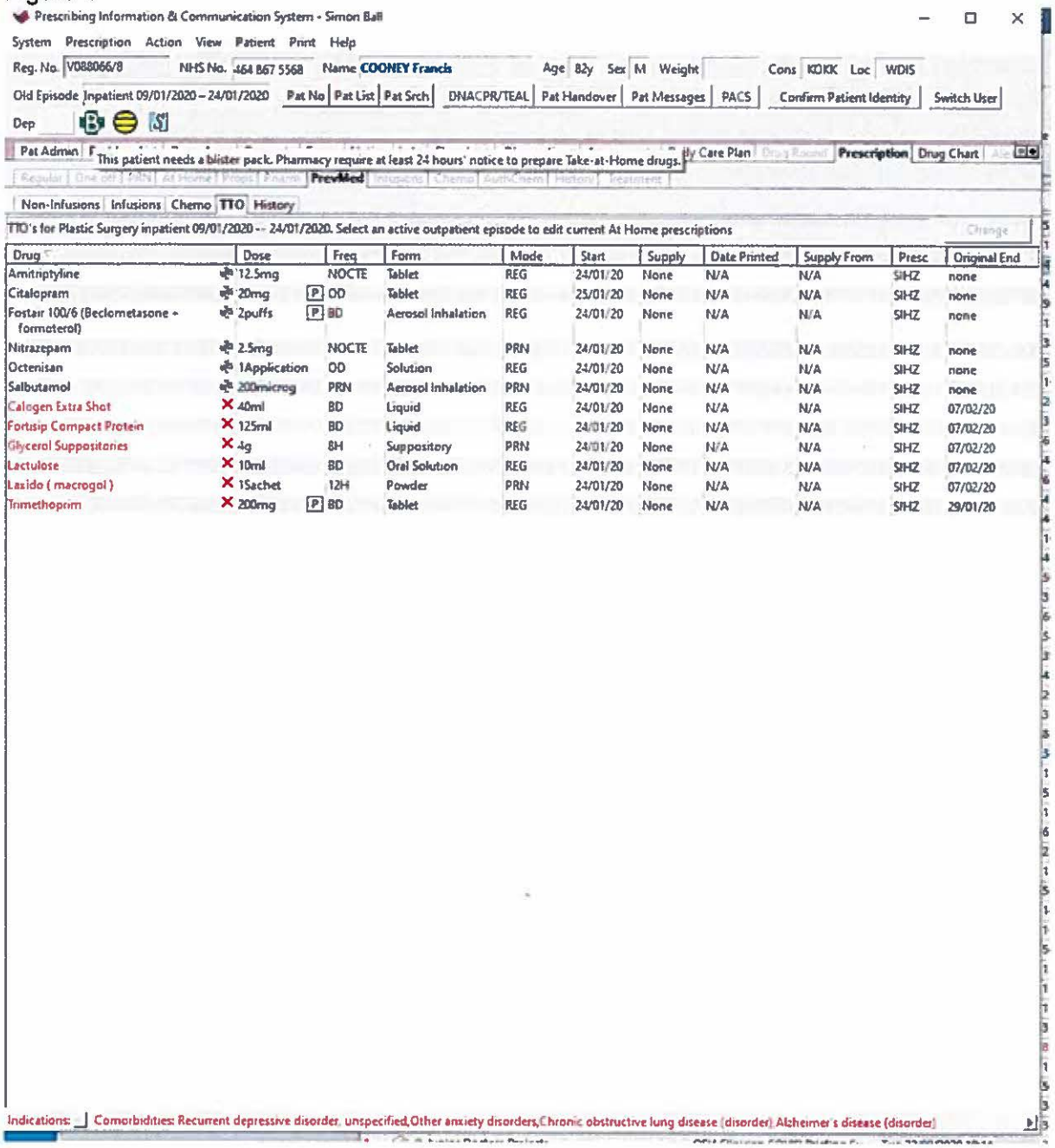
I would like to assure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously which I hope is demonstrated in the steps we have taken in reviewing our systems and processes and raising awareness of the importance of clear communication and I would again repeat our unreserved apology to you and Mr Cooney's family for the inaccurate information provided during the Inquest process.

Yours Sincerely

[redacted]

Professor [redacted]
Chief Medical Officer

Figure 1


Prescribing Information & Communication System - Simon Ball
System Prescription Action View Patient Print Help
Reg. No. V088066/8 NHS No. 464 867 5568 Name COONEY Francis Age 82y Sex M Weight Cons KOKK Loc WDIS
Old Episode Inpatient 09/01/2020 – 24/01/2020 Pat No Pat List Pat Srch DNACPR/TEAL Pat Handover Pat Messages PACS Confirm Patient Identity Switch User
Dep
Pat Admin
This patient needs a blister pack. Pharmacy require at least 24 hours' notice to prepare Take-at-Home drugs.
Care Plan Prescription Drug Chart
Non-Infusions Infusions Chemo TTO History
TTO's for Plastic Surgery inpatient 09/01/2020 -- 24/01/2020. Select an active outpatient episode to edit current At Home prescriptions
Change
Drug Dose Freq Form Mode Start Supply Date Printed Supply From Presc Original End
Amitriptyline 12.5mg NOCTE Tablet REG 24/01/20 None N/A N/A SIHZ none
Citalopram 20mg P OD Tablet REG 25/01/20 None N/A N/A SIHZ none
Fostair 100/6 (Beclometasone + formoterol) 2puffs P BD Aerosol Inhalation REG 24/01/20 None N/A N/A SIHZ none
Nitrazepam 2.5mg NOCTE Tablet PRN 24/01/20 None N/A N/A SIHZ none
Octenisan 1Application OD Solution REG 24/01/20 None N/A N/A SIHZ none
Salbutamol 200microg PRN Aerosol Inhalation PRN 24/01/20 None N/A N/A SIHZ none
Calogen Extra Shot 40ml BD Liquid REG 24/01/20 None N/A N/A SIHZ 07/02/20
Fortisip Compact Protein 125ml BD Liquid REG 24/01/20 None N/A N/A SIHZ 07/02/20
Glycerol Suppositories 4g 8H Suppository PRN 24/01/20 None N/A N/A SIHZ 07/02/20
Lactulose 10ml BD Oral Solution REG 24/01/20 None N/A N/A SIHZ 07/02/20
Laxido (macrogol) 1Sachet 12H Powder PRN 24/01/20 None N/A N/A SIHZ 07/02/20
Trimethoprim 200mg P BD Tablet REG 24/01/20 None N/A N/A SIHZ 29/01/20
Indications: Comorbidities: Recurrent depressive disorder, unspecified,Other anxiety disorders,Chronic obstructive lung disease (disorder) Alzheimer's disease (disorder)