1397-13

Burton Hospitals NHS
NHS Foundation Trust

Our Ref: HA/CS/ELS

31 January 2014

Queen's Hospital
Belvedere Road
Burton Upon Trent
Staffordshire
DE13 0RB

Telephone: [redacted]

**PRIVATE & CONFIDENTIAL**
Mr A Haigh
HM Senior Coroner
Coroner's Office
No. 1 Staffordshire Place
Stafford
ST16 2LP

Dear Mr Haigh

**Re: Elsie May TREECE (Deceased)**

In response to the HM Coroner's Prevention of Future Death Report received by the Trust following the inquest of Elsie May Treece [B332952].

In relation to incident reporting, I can confirm that training has always been provided for staff in relation to the reporting of incidents. This training has been delivered by the Clinical Risk Team in collaboration with the Learning and Development Team. Registers of attendance are collated by the Learning and Development Team and entered against the annual training requirements for each staff member and uploaded onto the ESR system.

Currently training is provided at Trust induction days, mandatory update training days, online training and ad hoc sessions in ward and department areas and provided for medical staff in different forum. Ad hoc training is provided as requested, and in light of this request for information from HM Coroner, we have arranged to provide additional training and support for Ward 6.

More recently, we have linked in with the University to raise awareness with student nurses surrounding the importance of incident reporting and the feedback mechanisms which occur.

Whilst it has been acknowledged that there was a period of downtime for the HISS computer system which occurred during the time of Mrs Treece's admission, contingency plans were put in place which instigated the use of paper based documentation, and including paper based incident forms. Those paper incident forms received during and following the downtime were manually entered into the electronic system.

With regard to point 2 of concern, as to the reasons why Mrs Treece did not have a CT scan. Please find attached letter from [redacted] outlining the reasons why a CT scan was not appropriate.

Yours sincerely

**Helen Ashley**
**Chief Executive**

Att.

Burton Hospitals NHS
NHS Foundation Trust

Queen's Hospital
Belvedere Road
Burton upon Trent
Staffordshire
DE13 0RB

Telephone [redacted]

Our ref JAC/EG

23 January 2014



[redacted]
Legal Services Manager
Queen's Hospital

Dear Bridget

**Re: Elsie May Treece**
**DoB: 2/6/1918**

Mr Haigh has asked the Trust to look at the case of Mrs Elsie Treece who attended the Emergency Department on 18 July 2013 at 0317hrs. His specific question was to find out why Mrs Treece did not have a CT scan on that day.

She was seen by a Foundation Year 2 Doctor at 0400hrs, after having routine triage, which showed that she was alert with normal observations. The Doctor who assessed her noted that she was suffering from a head injury, following a fall from her bed, where she landed on the floor. She sustained a laceration to the right forehead, without any evidence of loss of consciousness, vomiting or reduction in her normal conscious level. He also noted that she was not on Warfarin and was alert and comfortable on examination.

I have also looked at the West Midlands Ambulance Service documentation regarding her transfer to the Emergency Department and again, this corroborates the Doctor's notes where there was no evidence of loss of consciousness and also she was alert with a normal conscious level.

Her symptoms and signs were not consistent with a significant head injury and therefore we would not have proceeded to do a CT scan as per NICE head injury guidance. There was no indication to carry out a CT scan at the time.

Many thanks

Yours sincerely

[redacted]
**Lead Consultant in Emergency Medicine**