Department of Health

From Dr Dan Poulter MP
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Mr J Pollard
Senior Coroner
Coroner's Court
1 Mount Tabor Street
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10 JUL 2014

Dear Mr Pollard,

Thank you for your letter following the inquest into the death of Gary Bradshaw. In your report you conclude that the medical cause of death was myocardial infarction, dystrophic myocardial calcification and hypercalcaemia due to a tumour of the parathyroid gland and bronchopneumonia.

I understand that in May 2011 Mr Bradshaw attended Stepping Hill Hospital in Stockport reporting to the Accident and Emergency Department that he was suffering from right sided groin pain. By July 2011 an ultrasound scan had revealed that he was suffering from kidney stones. In April 2012 it was noted that he had high levels of calcium in his urine and in June 2012 he was reviewed by a urological surgeon who ordered serum calcium investigations to be carried out. This surgeon also prescribed and administered bendroflumethiazide for Mr Bradshaw before the results of the blood test were known.

At the end of June Mr Bradshaw again presented to the Emergency Department and this time he collapsed in the waiting area. On 2nd July it was assessed that he was suffering from hyperparathyroidism. He then remained in hospital until his death on the 12th July.

You found that during the time before Mr Bradshaw's admission to hospital and during his last hospital admission, a number of opportunities were missed, some of which might have alleviated his level of suffering and others which might have extended his life expectancy.

You raise a total of twelve concerns of which the following four (numbers 3, 8, 11 and 12 in your letter) are for our attention and that of Stockport NHS Trust:

- blood tests were ordered but the patient was prescribed and administered bendroflumethiazide before the results of the blood tests were known, something which the expert witness at the inquest described as contraindicated.

- the hospital laboratory only 'flags-up' the blood results if the blood- calcium levels exceed 3.5mmol/l or more of serum calcium. The expert witness thought that this should occur at levels of 3.0mmol/l, and that this should be the national standard.
- you were told that a new electronic system of note keeping is being introduced at Stockport and throughout the NHS. You consider it would be helpful if that system had an in-built 'flag' which highlighted to a doctor that he or she was prescribing drugs before the requested blood/urine test results had been received.
- there seemed to have been a very subjective interpretation of the Early Warning Scores (EWS) at the hospital by using the 'manual' assessment method. You were told that an electronic version is being rolled out and you hope that this could be sooner rather than later as it would give a better and more objective assessment of the Early Warning Scores.

We have sought advice from the National Institute of Health and Care Excellence (NICE) concerning the first two issues above.

On your concern about the prescription of bendroflumethiazide, NICE confirm that the clinical circumstances outlined in your report are not currently covered in any published NICE guidance. However, NICE will be developing a guideline on renal stones, which is yet to be commissioned.

In response to your concerns about the reporting of blood test results, NICE do not stipulate laboratory reference values or 'flags' on when to alert clinicians to blood test results. As this is not something that falls within NICE's remit, it is for individual NHS Trusts to review their own standards.

With regard to the third concern above, I assume you are referring to the Summary Care Record (SCR). I can confirm that flag system functionality is not within existing requirements for the SCR system nor are there any current plans for SCRs or SCR systems to introduce "an in-built 'flag' which would highlight to a doctor that he or she was prescribing drugs before the requested blood/urine test results had been received. This is a matter best left to the clinical and professional judgement of the doctor involved, with first-hand knowledge of the patient's circumstances.

Regarding the last point, it appears that you are referring to errors in calculating the overall Early Warning Score (EWS) from its individual components such as pulse, blood pressure, respiration rate, etc. Electronic hand-held devices are one potential solution to avoid error, as they can automatically alert medical or co-ordinating staff that a patient's score has exceeded a threshold. Staff training and better-designed paper charts, that make areas of concern visually obvious, are also helpful.

Even when the EWS has been correctly calculated, clinical interpretation is still essential. All other aspects of the patient's condition need to be taken into account in order to judge what clinical actions are needed in each individual case.

A range of resources are already available to help all organisations implement reliable use of EWS. The Royal College of Physicians (RCP) have led the development of a new National Early Warning Score (NEWS) which sets a clear national standard for the assessment and response to acute illness:

http://www.rcplondon.ac.uk/sites/default/files/documents/national-early-warning-score-standardising-assessment-acute-illness-severity-nhs.pdf

The NEWS described in these resources is in line with NICE recommendations on the care of acutely ill patients in hospital which can be found in their guideline, CG50:

http://www.nice.org.uk/CG50 .

NICE confirm that, whilst physiological examinations should be made and a clear written monitoring plan developed, there is no recommendation for the use of one model over another.

Instead the choice of a physiological track and trigger system should involve multiple-parameter or aggregate weighted scoring systems, which allow a graded response. NICE do specify that the scoring systems should:

- Define the parameters to be measured and the frequency of observations
- Include a clear and explicit statement of the parameters, cut-off points or scores that should trigger a response.

You may be interested to note that NICE also has a number of guidelines in development relating to various groups of acutely ill people in hospital:

http://www.nice.org.uk/guidance/indevelopment

As part of this work, N ICE is likely to consider whether there is sufficient evidence for recommending electronic hand held devices over other methods of calculating the EWS.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr Bradshaw's death to my attention.

Best wishes,

DR DAN POULTER