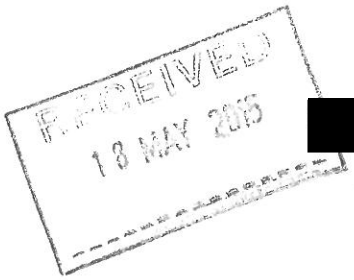
Bob

Central Manchester University Hospitals NHS

NHS Foundation Trust

Room 217
Medical Directors Office
Trust Headquarters
Manchester Royal Infirmary
Oxford Road
Manchester, M13 9WL

Tel: 0161 701 0205 [redacted]



14 May 2015

Miss J Kearsley
Area Coroner
Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

Dear Miss Kearsley

Re: Bryan Herbert WHITBY (deceased)

Thank you for your letter of 25 March 2015. I instructed the clinical team to review the case and have set out the answers to the points noted in the Regulation 28 notification below.

The deceased had been unwell for some time and had a history of Chronic Kidney Disease (CKD) Stage 3. He had been referred for a CT scan but the GP Practice were not aware of the date of the scan or that this would take place on 03 May 2014.

The Directorate Manager for Radiology has advised that Radiology would not normally inform a GP of scan dates or send the results to them unless they were the referring Clinician. The scan was requested on 29 April 2014 by [redacted] Surgical Registrar, in the lower gastrointestinal (GI) clinic.

The GP does need a complete picture of what investigations/procedures a patient has had as part of their secondary care episode but this would be communicated to the GP in a letter from the Specialist once all investigations were complete.

Blood tests taken on 02 May were not escalated by the GP or the Pathology Laboratory, and the scan on 03 May went ahead while he was still receiving Metformin medication. The Radiologist carrying out the scan did not have access to his blood results from 02 May and simply went off the results from the GP referral some time ago.

The Radiology Lead for Trafford Division has advised that their policy at that time was to check the most recent blood results within three months. The blood results reviewed were the most recent at the time they were checked and had been taken on 24 April 2014, which was nine days prior to the scan.

At this time, the eGFR result was 71 and there was no indication in the information the Radiology Department received that there was any concern over Mr Whitby's renal status. The Surgeon recorded on the referral form for the CT scan with contrast that Mr Whitby's eGFR was 71 and that he was taking Metformin for his Type II diabetes. These eGFR results did not cause concern as they were well within the Royal College of Radiologists and NICE guidance for giving contrast which is 50 for intravenous contrast and 60 for stopping Metformin.

The Radiology Department were unaware of the further blood tests taken at the GP Practice on 02 May 2014. Whilst these results were available on the same day on the Electronic Patient Record

(EPR) the Radiology staff would not have routinely looked for further results at that time unless they had been informed that there had been a change in Mr Whitby's condition. Given the short time between Radiology booking and scanning Mr Whitby, they did not look again on the system.

As a result of this incident, the Radiology Department have reviewed their practice in relation to the timing and assessment of renal function prior to intravenous contrast administration. Following this review they have implemented a process to check for any later results prior to giving contrast injections for CT scans as a routine protocol for all patients with known CKD.

I am sorry but there is no record of who requested further blood tests on 06 May 2014.

On the morning of 06 May 2014, Mr Whitby's blood tests from 02 May 2014 (eGFR 40 and Creatinine 148), were checked by the GP and the drop eGFR and magnesium, and the raised Creatinine were noted. The GP contacted the Locum On Call Medical Registrar at Trafford Hospital, [redacted] and asked advice. [redacted] advised that further bloods needed to be taken that morning and if no improvement, to refer to the Acute Medical Unit (AMU) at Trafford General Hospital. Mr Whitby then had some further blood tests taken at the GP Practice which arrived at the Pathology Laboratory at Trafford Hospital at 14:27 hours on 06 May 2014.

At approximately 12:00 hours on 07 May 2014, Mr Whitby's GP reviewed his blood results and noted his eGFR was 11 and Creatinine 448 which can indicate Stage 5 CKD. Mr Whitby's GP contacted the Locum Medical On Call Registrar at Trafford Hospital, [redacted] who accepted Mr Whitby for admission to the Acute Medical Unit (AMU). [redacted] completed a GP referral proforma and recorded clinical details of Acute Kidney Injury (AKI) or Chronic Kidney Disease (CKD) with drop in eGFR on the GP referral form. The GP Practice contacted North West Ambulance Service (NWAS) at 12:29 hours to arrange for them to collect Mr Whitby and bring him to the AMU.

The results of the blood tests on 06 May should have resulted in urgent discussion with the Mr Whitby's GP or Mr Whitby himself. There was no escalation of these results by the Biochemistry Laboratory.

Mr Whitby's blood results were not escalated by the Chemical Pathology Laboratory on 06 May 2014 as the 500umol/L threshold followed in the Laboratory at that time for Creatinine had not been breached. Chemical Pathology have now lowered the telephoning limit for Creatinine results from 500umol/L to 400umol/L and these results are telephoned through on the same day.

Consultant Chemical Pathologist, [redacted] and [redacted], Chief Biomedical Scientist in Chemical Pathology, have confirmed that a review of the processes for urgently notifying GPs of abnormal test results has been undertaken. On 09 March 2015, the Biochemistry Department went live with an Acute Kidney Injury (AKI) alert system. In future all Stage 3 alerts will be telephoned as soon as possible on the same day. Stage 1 and 2 alerts will be reviewed on a case by case basis.

Despite blood results, Mr Whitby was not admitted to hospital as an emergency and there was a delay in recognising the seriousness of these results. Training for junior members of staff on AKI has now been delivered.

When Mr Whitby was admitted into hospital, there was a failure by the treating medical staff to recognise his serious medical condition and then a failure to carry out the required medical treatment.

The high level investigation into the care and treatment of Mr Whitby acknowledges that the severity of his illness was not recognised by the admitting team in the AMU until he became clinically unwell. Due to this, he was not appropriately managed on admission.

Following the high level investigation, a detailed action plan was agreed and progress was monitored via the Divisional and Directorate Clinical Effectiveness Committees. All actions are now complete.

The Trust's AKI guidelines, which support the recognition of severity and the management of AKI in line with NICE guidance August 2013, have been fully implemented and are clearly displayed on the Information Board and in the Doctors' office on the AMU. The guidelines are also now included in the Handbook provided to Locum Doctors.

Medical and nursing staff on the Acute Medical Unit attended a debriefing session to discuss the care and treatment of Mr Whitby and the lessons learned. His case was also presented to medical staff at a Medical Grand Round and was presented more widely at the Divisional Audit and Clinical Effectiveness (ACE) day on 17 October 2014. The case was presented by [redacted] Consultant, who discussed the missed opportunities and the chain of events. The presentation of Mr Whitby's case was followed by a presentation by [redacted] Consultant in Nephrology and Intensive Care Medicine, who explained to staff how the Trust is tackling AKI. [redacted] explained how AKI was a safety priority for the Trust and also explained the role of the Renal team and of the AKI Specialist Nurses. [redacted] also discussed the AKI e-alert system which at that time was under development but has since been successfully implemented Trust wide.

Mr Whitby's case has also formed an important part of lessons learnt teaching for Junior Doctors across the Trust and this was followed by teaching of the recognition and management of AKI.

The Inquest also heard evidence that Mr Whitby required transfer to the High Dependency Unit but this could not take place immediately as two Critical Care Nurses were required and one had been sent to Manchester Royal Infirmary as was the practice if there were no patients in the HDU at the start of their shift.

Since the date of the incident regarding the transfer of Mr Whitby to the High Dependency Unit, two Critical Care Nurses have been on site at Trafford at all times. The Critical Care Service has recently reviewed the use of Trafford's High Dependency Unit and is widening the scope for the type of patients who can be nursed there in the future. This means that not only will the Critical Care Nurses be based on the Trafford site – they will be based at all times on the High Dependency Unit.

I hope this letter answers your concerns and gives you and Mr Whitby's family assurance that lessons have been learned.

Yours sincerely

[redacted]

[redacted]

Medical Director & Caldicott Guardian
MAHSC Honorary Clinical Professor, University of Manchester