Epsom and St Helier NHS
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NHS Trust

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HM Coroner Mr Simon Wickens
Station Approach
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03 June 2015

Dear Mr Wickens,

Mr Kenneth John Williams (Deceased)

I write further to your letter of 8th April 2015 regarding the sad death of Mr Williams. I understand the case was heard with you residing and a Regulation 28 Report was issued, which the trust has now had an opportunity to fully consider. The case and your recommendations have been fully considered by [redacted] Clinical Director for Medicine, [redacted] Head of Nursing for Medicine and Wendy Millar, Quality Manager for General Medicine. The trust board of directors are also aware of the case and the case has been discussed at a serious incident panel. I shall deal with the concerns you raise, in the order that you have raised them in box five of the Regulation 28 report.

1. **Action is required to ensure that previous radiology, patient's medical history and medication is always considered before a chest drain insertion or invasive procedure is undertaken.**

   a. Medical Proforma

   The trust fully acknowledges the importance of considering previous medical history of patients as part of the assessment and diagnosis process. We have introduced a medical proforma to support clerking of patients and the proforma requires the patient's medical history and medication to be taken. I attach a copy to this letter as *Appendix A.*

   b. Training

   Mr Williams' case is the focus of some of the trust's current training in the use and insertion of chest drains. As part of this training, medical staff are reminded of the requirement to consider the historical radiology and medical history of the patient as part

of the decision-making process before a drain is inserted. The trust's respiratory team is heavily involved in the training programme and experienced respiratory physicians give some of the sessions themselves.

c. Upgrade of the trust's radiology computer system (PACS)

One of the difficulties the clinicians found when considering Mr Williams' historical radiology was the images were not easily available. A search for patients with more common names brought up multiple images for multiple patients, which needed to be searched through manually. This made assessing historical radiology difficult and there was the potential for important imaging being missed. The trust has since moved from a BT PACS system, which was difficult to navigate around, to a new system called Sectra PACS. The new system has a default setting to include a patient's date of birth and the hospital number can be searched. This has made the search of patient's historical radiology far easier and quicker and it has greatly reduced the possibility of an image being missed.

2. Action is required to ensure a respiratory consultants opinion is sought where possible before inserting a chest drain.

a. Pathway/Guidance for Spontaneous Pneumothorax

A pathway has been created for patients presenting with suspected spontaneous pneumothorax and it has been reviewed by [redacted] the Clinical Director for Medicine. The pathway specifically includes the respiratory team in the discussion prior to the insertion of a chest drain. I attach a copy of the pathway as *Appendix B*.

b. Training

As I have mentioned above, the respiratory team provide in-house training on the insertion and use of chest drains. All clinicians are reminded during these training sessions that the respiratory team must be involved in the patient's care following the insertion of a chest drain.

3. Action is required to ensure the respiratory team is made aware of all patients who have had a chest drain inserted.

This action is linked to action two above and the actions the trust has taken in terms of introducing the new pathway and the training we provide will help to ensure the respiratory team are fully involved in the patient's care.

a. Direction from the Joint Medical Director

[redacted] Joint Medical Director, has been very keen that the trust takes all learning from this case. I understand she has presented Mr Williams' case at a grand round meeting, which is the trust's means of cascading learning from key cases and which is attended by clinicians at the trust. [redacted] also sent an e-mail out to every trainee doctor at the trust setting out the process the trust expects its physicians to follow, including involving the respiratory team in the care of every patient who has had a chest drain inserted *(Appendix C)*. [redacted] also sent a further e-mail out to every consultant at the trust, dated 26th March 2015, stating that the respiratory team must be informed of

all patients who have had a chest drain inserted and this e-mail has been cascaded down to their teams (*Appendix D).*

4. **Action is required to ensure a patient's previous medical history, historical imaging and medications are always reviewed anew by any subsequent medical team receiving the patient from Accident and Emergency.**

   a. Review of handover process

- In order to answer this concern, the medical team have undertaken a review of the handover processes in order to support and improve the handover from the Accident and Emergency team to the medical team.

  An adult transfer checklist and four hour plan has now been created, which includes the requirement to discuss with the patient and document all medications they are on, as well as considering historical radiology (*see Appendix A).*

  A telephone handover document has been created, which is designed to hand-over the last key observations that were undertaken as well as providing the previous medical history for the patient (*see Appendix E).*

5. **Action is required to ensure all medical staff are trained on how to access historical imaging.**

   a. Updated radiology system

   I am told the main difficulty the medical staff faced when trying to identify and assess historical imaging, was the way the computer system was set up. The system was not designed by the trust and it has been provided by an external provider independent to the trust. The trust has been working with the external company to upgrade the system and the trust has gone through a transitional period from a system called BT PACS to a new Sectra PACS system. One of the main advantages of the new system is the availability of more search fields in order to identify the patient being and the search will no longer bring up multiple patients with the same name.

   The new Sectra PACS software has the date of birth as one of the default settings, so staff searching for historical radiology will search under both the name and the date of birth in order that the clinicians only need to search through images relating to the patient they are treating. This has increased the accuracy of the searches being undertaken and it means a clinician can review the images a lot quicker than was previously possible.

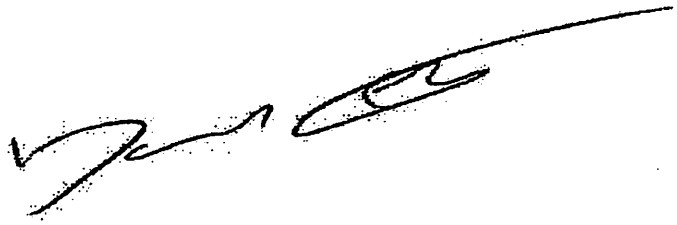
The trust regrets the failings in Mr Williams' care and all the staff involved in his treatment and care have been affected by the unexpected outcome following the insertion of the chest drain. The incident has been taken very seriously by the trust and an internal investigation was undertaken to review the treatment and care that was provided. As you are aware, the trust took the decision to commission two independent expert opinions into the case to add a further review of the treatment and we have fully considered all learning from the case. The independent reports have been made available to the members of staff involved in Mr Williams care and they have been discussed within the relevant departments.

I should like to reassure you and the family that the trust has a robust framework for cascading learning. Mr Williams' case has been discussed in the departments that provided

his treatment and care and his case has been discussed at our Mortality Meeting and at our Governance Meeting as well as being presented by [redacted] at a grand round.

I do hope this letter detailing the actions the trust has implemented following Mr Williams' case gives reassurance to both Mr Williams' family and to you that the systems we have in place are safe in order to reduce the possibility of such an incident occurring again. I should like to thank you for highlighting your concerns and giving the trust the opportunity to consider all learning from this case afresh. Please do revert back to me if I can be of any further assistance.

Yours sincerely



Daniel Elkeles
Chief Executive