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Professor Adam Cairns
Chief Executive

26 November 2015

Private and Confidential

Mr A Barkley
Senior Coroner
Coroner's Court
Central Police station
Cathays Park
Cardiff
CF10 3NN

Dear Mr Barkley

Regulation 28 report – Mr Geoffrey Parry (died 29th June 2015)

Thank you for your letter dated 7 October 2015, which was received by the Health Board on 8 October 2015.

I have reviewed the points raised within the Regulation 28 report regarding the sad death of Mr Parry. My response has been informed by senior clinicians responsible for the clinical care provided to Mr Parry and other appropriate colleagues.

I recognise that this will have been a particularly difficult time for Mr Parry's family and would wish to offer my sincere condolences on behalf of the University Health Board.

For ease of reference, I will respond to each of the matters of concern you have raised in turn.

- **An ECG test undertaken on 21 April 2015 was not available to the reviewing consultant anaesthetist prior to surgery. The evidence suggested that there was a problem within the hospital, not specific to ECG tests whereby results from investigative tests and scans are not kept with the patient's medical notes. In this instance, it appeared that there was a facility for the result of the ECG to be electronically uploaded onto the hospital computer system but this had not happened.**

The University Health Board has taken the opportunity to completely review the systems and processes in place for the storage of ECG investigations. The Cardiac Physiology Department hosts a system called MUSE which allows for electronic storage of ECGs. Currently, a limited number of departments utilise this system.

An upgrade to the MUSE software is anticipated to be released shortly. When this occurs, it will allow for connectivity between the MUSE system and Clinical Portal. The Clinical Portal system records inpatient and outpatient activity; test results; clinical correspondence amongst other patient-related activity. Clinical Portal is widely accessible to clinical staff.

In order to strengthen use of the MUSE system across the Health Board a number of actions are planned. An improvement plan to support this is in development and will address numerous areas including:

- an ECG training needs analysis;
- improved identification of staff members undertaking ECGs on patients
- review of ECG machines suitable for purchase to ensure they can connect to the MUSE system and improve patient identification on ECGs undertaken;
- review of ECG machine maintenance with the Clinical Engineering department and
- a review of the use of the MUSE system to ensure the Cardiac Physiology Department and infrastructure in place to support the MUSE system can sustain an increase in ECG activity using the software.

In order to progress this work over the coming weeks, a paper will be presented to the Health Systems Management Board in December 2015.

- **An intravenous line administering noradrenaline was accidentally disconnected from Mr Parry causing his blood pressure to drop significantly to the point of requiring cardiopulmonary resuscitation.**

An improvement plan has been put in place to strengthen intravenous infusion labelling practice and is being implemented and monitored by the Critical Care department. An audit of current practice undertaken in November 2015 demonstrates satisfactory compliance but with further room for improvement. A standard operating procedure regarding the management of intravenous infusion line is now in development. Appropriate moisture resistant stickers have been sourced to improve line labelling procedures. The Practice Educator team have implemented training sessions and posters to highlight the incident and arising issues to staff.

Arrangements to share the learning from this incident are in place for the Cardiothoracic and Critical Care Directorate in January 2016 and for the Specialist Services Clinical Board in February 2016.

Your findings at Mr Parry's inquest are of relevance to all Clinical Boards in the University Health Board. A copy of your Regulation 28 report and my response will be shared with all Clinical Boards with the intention that all clinical areas will review the actions undertaken to date and assess areas of clinical risk in their directorates to minimise risk of recurrence of the matters of concern.

I hope that the information set out in this letter provides you with the assurance that the Health Board has fully considered the issues raised as a consequence of the inquest into Mr Parry's death and your letter of 7 October 2015, and has taken appropriate action in response.

Yours sincerely

Professor Adam Cairns
Chief Executive