REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Rt Hon. Jeremy Hunt, Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS **2.** Ms Trish Anderson, Chief Officer (Chief Executive) Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan WN1 1NJ **3.** Mr Andrew Foster, Chief Executive Wrightington Wigan & Leigh, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN **4.** Mr Simon Barber, Chief Executive 5 Boroughs Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington WA2 8WA
1	**CORONER** I am Alan Peter Walsh, Area Coroner, for the Coroner Area of Manchester West
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26th January 2015 I commenced an Investigation into the death of Harry Pryal, 84 yrs, born 23rd September 1930. The Investigation concluded at the end of the Inquest on 4th September 2015. The medical cause of death was 1a) Bronchopneumonia 1b) Traumatic Spinal Cord Injury The conclusion of the Inquest was Harry Pryal died as a consequence of injuries sustained in an accidental fall in circumstances where an X-Ray identifying a suspected cervical spine fracture was not reported and the fracture was not diagnosed for a period of 5 days following the X-Ray and 6 days following the fall in which the injury was sustained.
4	**CIRCUMSTANCES OF THE DEATH** 1. Harry Pryal died at Salford Royal Hospital, Eccles Old Road, Salford on the 8th January 2015. 2. Mr Pryal had been admitted to the Lakeside Unit, Leigh Infirmary, Leigh on the 5th November 2014 complaining of ongoing low mood with reduced energy levels, poor motivation, hopelessness and decreased

appetite. The Lakeside Unit is under the Governance of the 5 Boroughs Partnership NHS Foundation Trust (hereafter referred to as '5BP') and is on the same site as Leigh Infirmary, which is under the Governance of Wrightington Wigan and Leigh NHS Foundation Trust (hereafter referred to as 'WWL').

3. There was a Service Agreement for the provision of Radiology between the 1st April 2014 and the 31st March 2015 between 5BP and WWL, which included the provision of Radiology at Leigh Infirmary, Leigh and a copy of the Service Agreement is attached hereto.

4. On the 30th December 2014 Mr Pryal had a fall in his bedroom at the Lakeside Unit and on the same day a Doctor from the Lakeside Unit requested an x-ray examination by completing and submitting the appropriate form to WWL. The form requested x-ray examinations of chest, cervical spine and a shoulder.

   The x-rays were conducted at the Leigh Infirmary, Leigh by WWL on the 31st December 2014 under the terms of the Service Agreement for the provision of Radiology. The x-rays were not reported in writing until the 14th January 2015, when the report referred to a separation of the spinous processes of C5 and C6 and disruption of the alignment of the facet joints below C5. The report also referred to further imaging indicated. The written report was only received on the 14th January 2015 after Mr Pryal's death, which occurred on the 8th January 2015

   During the evidence there was a conflict between 5BP and WWL with regard to the interpretation of the Service Agreement in relation to the reporting of x-ray examinations under paragraph 2.1 on page 15 of the Agreement. 5BP interpreted the reporting of the examination to be within 72 hrs of the examination whereas WWL interpreted the provision as web viewing of the x-ray within 72 hrs of the examination and the reporting of the examination at some time in the future without any time indication.

   The evidence at the Inquest from 5BP was that they were unable to view x-rays by use of web viewing because the software used by 5BP was not compatible and 5BP did not have a network connection to WWL for web viewing of the x-rays. Furthermore 5BP gave evidence that the Doctors and the Psychiatrists at the Lakeside Unit would not have the expertise to identify or interpret x-rays by web viewing without a formal report by a Radiologist.

5. The clinical lead Radiologist for WWL gave evidence at the Inquest that he was not aware of the terms of the Service Agreement and that Mr Pryal was treated as an outpatient for x-ray examination by WWL at Leigh Infirmary, whereas the agreement provides that Mr Pryal should have been treated as an in-patient which would have affected the time lines for reporting x-ray examinations.

6. The evidence at the Inquest indicated that Doctors in Psychiatry at the Lakeside Unit would be dependent upon referral to and advice from the

medical team at WWL based at the Royal Albert Edward Infirmary, Wigan (hereafter referred to as 'RAEI') for treatment and care of patients in the Lakeside Unit with regard to any physical health needs.

On the 1st January 2015 at 03.35 hrs a Doctor from the Lakeside Unit made a note that he discussed Mr Pryal with the on call medical registrar at the RAEI and he made a note with regard to a plan in relation to medication and follow up of the chest x-ray. The note did not refer to the name of the medical registrar at RAEI.

The evidence given by witnesses from WWL showed that any referrals by health professionals outside WWL would not be noted and there would be no reference on any system or notes held by WWL with regard to the name of the Doctor giving advice nor with regard to the details of the advice.

Furthermore evidence was given that the absence of notes in relation of such matters was not limited to WWL and the same procedure existed in many, if not all, Hospitals nationwide.

7. On the 2nd January 2015 Mr Pryal was reviewed by a Doctor at the Lakeside Unit and there was ongoing deterioration in his presentation and he was drooling from his mouth with increased pain. There was a note that his neck was slightly deviated to the right side and he reported difficulty in raising his left hand. A CT scan was requested and the Doctor liaised with the medical team at WWL requesting an urgent transfer, a complete physical examination and an urgent CT scan in view of him having had a stroke.

   Mr Pryal was transferred to the RAEI on the 2nd January 2015 and the notes accompanying Mr Pryal to the RAEI referred to the history of falls x 3 and other conditions but did not refer to the x-rays on the 31st December 2014, nor a report in the 5BP notes that "Harry self reported that his neck was sore and that he cannot straighten his neck posture". The notes accompanying Mr Pryal to the RAEI also mentioned "need for a CT scan to rule out a stroke".

8. When Mr Pryal arrived at the RAEI he had a CT scan of the head and brain which reported moderate cerebral atrophy with no evidence of an acute stroke in the form of a bleed or an infarct.

   On the 3rd January 2015 Mr Pryal was seen by the Consultant Stroke Physician, who suspected that Mr Pryal may have had a minor stroke and he advised to continue further care on the stroke pathway. The Consultant gave evidence at the Inquest that he was not aware of the x-rays conducted on the 31st December 2014 and he was not aware of the information relating to the fall nor the neck pain, particularly the report that Mr Pryal's neck was sore and he could straighten his neck posture, as recorded in the 5 BP notes on the 1st January 2015. The Consultant also gave evidence that if he had been aware of the above information he would have looked at the x-rays and taken further action with regard to the symptoms, in addition to advising care on the stroke pathway.

9. On the 5th January 2015 at 10.30 hrs a FY1 Doctor on the Stroke Unit at RAEI recorded that Mr Pryal was complaining of neck pain and had weakness in both the upper limbs. The Doctor arranged either an urgent MRI scan of the brain and spine or an urgent CT scan of the cervical spine.

10. The scans were discussed at a Neuro-Radiology MDT Meeting on the 6th January 2015 when the x-ray of the cervical spine conducted on the 31st December 2015, which was not reported in writing at that time, was considered by a verbal report for the first time and it was noted from the x-ray that there were abnormalities in the region of C5/C6 with subluxation and the meeting noted the possibility of possible cervical spine fracture.

11. On the 6th January 2015 a MRI Scan of the whole spine was done and Mr Pryal was referred to the Spinal Neurosurgical Unit at the Salford Royal Hospital (hereafter referred to as 'SRH'). Mr Pryal was transferred to SRH on the 7th January 2015 when it was obvious that Mr Pryal had a chest infection, which was being treated with antibiotics. In fact there was evidence that Mr Pryal was suffering with a suspected chest infection on the 30th December 2014 at the Lakeside Unit when treatment with antibiotics was commenced.

    The Consultant Spinal Surgeon gave evidence that if he had been aware of the findings on the x-rays conducted on the 31st December 2014 he would have requested an immediate CT scan with a view to a transfer to the SRH to conduct surgery to stabilise the cervical spine of the fracture. When Mr Pryal was transferred to the SRH on the 7th January 2015 he refused surgery in relation to the spinal fracture but he did accept antibiotics in relation to the chest infection. The Consultant Surgeon was satisfied that Mr Pryal had capacity to make the decision but he also obtained advice from a Consultant Psychiatrist to confirm that Mr Pryal had sufficient capacity to refuse surgery.

12. Mr Pryal was treated with antibiotics for the chest infection but deteriorated and died on the 8th January 2015.

CORONER'S CONCERNS

During the course of the Inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

1. During the Inquest evidence was heard that

    i. 5BP contact WWL for advice in relation to medical treatment for patients at the Lakeside Unit on a regular basis as a matter of protocol. The Doctors in psychiatry at the Lakeside Unit, are

dependent upon such advice for the treatment and care of patients.

The evidence identified that there is no note of the advice in the records maintained by WWL, neither to identify the Doctor giving advice nor the content of the advice. Furthermore evidence was given that this was a situation arising on a nationwide scale. The absence of any notes prevents a record of the advice for the purpose of continuity of treatment and any subsequent referrals, particularly in a case when the Doctor giving the advice is no longer available and further advice is requested by the referring Doctor for medical treatment.

ii. The Service Agreement entered into between 5BP and WWL for the period from the 1st April 2014 to the 31st March 2015 was the subject of different interpretations by each Trust. There was confusion in relation to the prioritisation of imaging and there was a fundamental conflict in relation the interpretation of clause 2.1.

The Agreement provided for meetings between nominated officers from each trust at intervals not exceeding every 3 months from the effective date of the Agreement to consider any issues arising from the operation and performance of the Agreement, as provided in paragraph 14.1 on page 10 of the Agreement. The evidence of the Inquest confirmed that no meetings had taken place during the concurrence of the Agreement and there was no proactive involvement of the nominated officers to identify any issues arising from the operation and performance of the Agreement. Furthermore evidence was given that there were similar Service Agreements for the period from 1st April 2013 to the 31st March 2014 and from the 1st April 2015 to the 31st March 2016 with similar provisions for meetings during the concurrence of the Agreements but no meetings between nominated officers had ever taken place.

The evidence identified a lack of liaison and understanding between 5BP and WWL in relation to the Agreement and their relationship, even in circumstances where both trusts are operating on the same site at Leigh Infirmary, Leigh.

During the Inquest WWL confirmed that they had similar Service Agreements in relation to the provision of services to health professionals in other areas of treatment and the provisions of all Agreements were similar and the provisions in all Agreements may not be performed in accordance with the requirements of each Agreement.

iii. The evidence given by WWL was that there were no time lines in relation to the reporting of x-rays performed at the Leigh Infirmary, other than national timelines, although it was accepted

that the Service Agreement provided that "urgent or unexpected significant clinical findings will be communicated to referring clinicians at the time of the Consultant Radiological reporting". It was accepted that if there was an unexpected significant clinical finding it would be necessary to communicate the finding to the referring clinician without delay.

WWL do not have any triage procedures in relation to x-ray examinations so that any "urgent or unexpected significant clinical finding" would not be reported to the referring clinician for some time after the examination. An early triage of the x-ray examination within a short period of the examination would allow any urgent or unexpected significant clinical finding to be communicated to the referring clinician without delay.

iv. 5BP accepted that the Service Agreement provided for web viewing of the x-rays but accepted that the software operated by 5BP does not allow web viewing of x-rays and 5BP did not have network connections to view the x-rays electronically by access to the WWL network. In any event the Consultant Psychiatrist from the Lakeside Unit indicated that the Doctors in her team based at the Lakeside Unit, may not have the expertise to interpret the x-rays on web view and the Doctors would be dependent upon a formal report, either verbal or written, from the Radiologist.

v. The evidence at the Inquest revealed that the notes completed by clinicians at the Lakeside Unit, failed to identify the times of actions by them and in one note failed to identify the identity of the clinician making the note. The notes were inadequate, particularly the notes which accompanied Mr Pryal on his transfer from the Lakeside Unit, to RAEI.

The details to be included in a request for x-ray examination and the fact that an urgent x-ray examination required either a telephone call to the Radiologist or a note of priority on the x-ray form did not appear to be understood by clinicians at the Lakeside Unit, and demonstrated a lack of liaison and understanding between the two Trusts, which would be necessary to allow the terms of the Service Agreement to be operated and performed.

vi. Evidence was given at the Inquest that there was no physiotherapy or occupational therapy at the Lakeside Unit to deal with the physical health needs of any patients on the Unit. There was no Service Agreement for the provision of physiotherapy and occupational therapy and no understanding as to who would provide such services. The evidence indicated that the Clinical Commissioning Group in Wigan would provide the services and 5BP were not in a position to enter into agreements for the provision of services from elsewhere. Evidence was given by 5BP that the Clinical Commissioning Group in Wigan had not provided services so that the physical health needs of

patients in the Lakeside Unit, were not being satisfied in relation to physiotherapy and occupational therapy.

vii. The evidence raised concerns that there is a risk that future deaths will occur unless action is taken to review the above issues.

2. I request you to consider the above concerns and to carry out a review with regard to the following.

i. <u>The Secretary of State for Health, 5BP and WWL.</u>

The provision of notes within hospital records in relation to any telephone referrals or other referrals from health professionals for advice in relation to the treatment and care of a patient. The review should include the retention of such notes for observation by other clinicians who may become involved subsequently to ensure continuity of advice in relation to treatment and care.

The review is requested by the Secretary of State in view of the evidence that the absence of notes is a problem on a nationwide scale.

ii. <u>5BP and WWL</u>

A review of the liaison, understanding and interpretation of the provisions of the Service Agreement in relation to Radiology for the period from the 1st April 2015 to 31st March 2016 and any subsequent years, taking account of the evidence heard at the Inquest. The review should include the operation and performance of the terms of the Agreement and should extend to the involvement of the two Trusts, particularly on the same site at Leigh Infirmary, Leigh.

The review should also take account of any other Service Agreements in existence and entered into by both trusts either collectively or individually.

iii. <u>5BP and WWL</u>

A review of the electronic systems, which allow access by 5BP to network connections in relation to WWL systems, particularly to allow web viewing of x-ray examinations in accordance with the Service Agreement.

iv. <u>5BP</u>

A review of the notes in relation to names, times and content and the provision of training or retraining of clinicians and all staff in relation to the recording of appropriate notes, including requests for x-ray or other examinations and transfers to other hospitals.

	v. WWL A review of the reporting times for x-ray examinations with particular reference to triage to identify any urgent or unexpected significant clinical findings, which will need to be communicated to the referring clinicians at the earliest time. vi. Clinical Commissioning Group Wigan and 5BP A review of the provision of physiotherapy and occupational therapy to deal with the physical health needs of patients at the Lakeside Unit, to ensure that appropriate treatment is available to those patients.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd November 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] Mr Pryal's son. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated** **28th September 2015**
	Signed **Alan P Walsh**