[redacted]

Central Manchester University Hospitals NHS

NHS Foundation Trust

Trust Headquarters
Cobbett House
Manchester Royal Infirmary
Manchester M13 9WL
Tel No: 0161 276 4755
Fax No: 0161 272 6931

[redacted]

29th November 2016

Ms F Borrill
HM Area Coroner
Manchester City Area
HM Coroner's Office
PO Box 532
Manchester Town Hall
Albert Square
Manchester
M60 2LA

Dear Ms Borrill

Re: Inquest touching the death of Amelia Calvo

I am writing in response to your letters of 18 May and 26 October 2016 regarding this matter. I would like to apologise for the delay in responding to your initial letter.

Point 1

Request for advice on how competing requirements to attend meetings at lunchtime and be present for Team Briefings for afternoon surgery can be put into effect so that patient safety is not compromised

Work has been undertaken in RMCH to ensure clinical engagement with the Team Brief:

- The list used within the Team Brief was revised to address potential gaps in the original Brief and piloted. This work was clinically led and was rolled out to the CEPOD Theatre in June 2016 and is now used in all RMCH Theatres. This includes:
  - an Introductions Board has been implemented which includes a check of the box on the Team Brief board supporting the presence of all involved staff including the Lead Operating Surgeon and Anaesthetist
  - increased relevance for clinical staff with changed order of items within the Team Brief (surgical and anaesthetic plan are now discussed at the start of the Team Brief) and more room on the board for the 'Any Problems' section

- Operating Surgeon for the procedure; if the Operating Surgeon is not present the patient will not be sent for. Within working hours the presence of key staff (including the Operating Surgeon) has improved; out of hours (nights and weekends, when the Operating Surgeon may not be resident on the hospital site) issues can arise with the attendance of the Operating Surgeon; advice is that the patient must not be sent for until the Team Brief has taken place with the Operating Surgeon present

The team who have led on the above changes continue to review this on a regular basis.

Point 2

[redacted] were caused considerable distress by the use of the word 'outcome' in the High Level Investigation report. HM Area Coroner was told this referred to the fact that Amelia would have died in the future in any event of the, at that stage, undiagnosed Edwards Syndrome but [redacted], one of the investigation team, did concede that the use of the word 'outcome' was insensitive in all the circumstances

Our understanding, through discussion and following receipt of a letter of complaint from Amelia's parents (dated 13.06.16), was that the concern related to the following wording in the conclusion of the report:

> *'These deficiencies should be urgently addressed in order to avoid recurrence of these events in future, in a situation which is likely to have more clinical significance'*

[redacted] complaint stated 'no parent should have to read that their child is not clinically significant'.

In the response to [redacted] complaint (dated 30.08.16), it was acknowledged that the phraseology was insensitive and that we were deeply sorry that this was not identified by anyone involved in the production and checking of the HLI report.

Point 3

Evidence that Mortality and Morbidity team meetings in the Paediatric Anaesthetic Department were not minuted. It is understood that those meetings are now minuted and the minutes circulated to clinicians. Request for confirmation of this

From January 2017, the Paediatric Anaesthetic Department's discussion of Mortality and Morbidity will take place as part of the agenda within the Trust wide Audit and Clinical Effectiveness (ACE) Days. These dates are planned in advance and attendance is supported by the cancellation of elective activity. [redacted], Clinical Lead – Theatres and Anaesthesia, has confirmed that when mortality and morbidity cases are discussed, summary notes will be provided to capture responses, recommendations, action plans or outcomes.

Anaesthetic deaths are rare, and the ACE day is considered an appropriate forum for a departmental discussion of mortality and morbidity. It is important to highlight that in addition, Royal Manchester Children's Hospital has a well-established Mortality Group whereby the final episode of care is reviewed by a Consultant who was not involved in the patient's care. These meetings are minuted and the minutes are circulated (to reviewing members and Consultant medical staff identified as involved during the patient's final episode of care at RMCH).

If you need any further information, please do not hesitate to contact me.

Yours sincerely

Sir Michael Deegan
Chief Executive