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Mrs L Hunt
HM Senior Coroner
Birmingham and Solihull Areas
Birmingham Coroner's Court
50 Newton Street
Birmingham
B4 6NE

Dear Mrs Hunt

This letter is in response to the Regulation 28 Report to Prevent Future Deaths Issued by Mrs Louise Hunt, Senior Coroner for Birmingham and Solihull, on 26 October, 2016 following the inquest into the death of AR, date of birth 25 March 1999.

The Matters of Concern raised in the Report were:

1. There was poor communication between both hospitals in relation to Alfie's condition and care. Details of his neurosurgical review on 16/05/16 were not made available to Russell's Hall Hospital. His clinical condition was not relayed to QE hospital on 27/05/16 or morning of 06/06/16. These were vital missed opportunities to transfer him back to QE for treatment. Both Trusts need to look at their communication systems and identify areas for improvement and to clarify if the NORSE system is effective. I heard evidence to suggest that all NORSE system entries cannot always be seen.

2. Education. It is important the clinicians in outlying hospitals understand how neurological referrals should be made and when. Better guidance and education is needed for outlying hospitals.

Norse is a secure messaging system that was developed initially to provide a more effective method of communicating with the Neurosurgical team about patients who required a neurosurgical opinion. Before Norse was developed contact with Neurosurgery at QEHB was via telephone. The on call registrar would spend the majority of their time answering the phone, often with unacceptable delays for the referring clinician and the patient. The Norse system has replaced the majority of those phone calls and has improved access to the Department. It allows a referral to be made and a response to be given, providing an audit trail that was not previously available.

We believe that Norse is an effective tool for communication between secondary and tertiary specialties which has improved access to specialties at QEHB and enhanced clinical governance around that process.

It is important to reflect on the effectiveness of any system when there has been a significant clinical incident. To that end the following meetings have been held to identify areas of concern that could be improved:

10 November, 2016: Round Table meeting at Queen Elizabeth Hospital Birmingham ("QEHB").

5 December, 2016: Meeting between clinical staff from Russell's Hall Hospital ("RHH") and QEHB.

Issues Identified:

1. The letter written following AR's attendance at the Neurosurgical Hot Clinic was written to the General Practitioner, but not copied to the patient or the referring doctor from RHH. There was a unacceptable 27 day turnaround for the letter.

2. AR declined admission from the Hot Clinic. His case was discussed with a consultant, but he wasn't reviewed by a consultant.

3. Visibility of patients on Norse at the referring centre is limited to the person who initiates the referral. There are exceptions. The case can be shared with another user or users, which did not happen in this case. There should be one or more 'super users' at the referring centre who have oversight of all activity on Norse. This is not currently in place at RHH.

4. There are difficulties obtaining information on patients seen at QEHB when they attend other hospitals as emergencies.

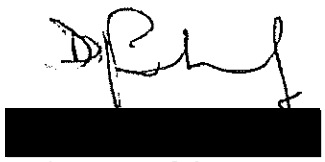
5. There is no Norse Users' Group

6. It was noted that there are no guidelines for the management of patients known to have hydrocephalus in the emergency setting.

The actions set out in the attached table have been agreed.

I trust that we have addressed the issues raised.

Yours sincerely



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