Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Legal Services Department
Trust HQ
Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

Tel: 01942 822937/2172
Fax: 01942 822170
Email: [redacted]
Web: www.wwl.nhs.uk

Mr Timothy Brennand
Assistant Coroner
Manchester West
HM Coroner's Office
Paderborn House
Howell Croft North
Bolton
BL1 1QY

31 July 2017

Dear Mr Brennand

Regulation 28 Response: Katherine Anne Derbyshire (Deceased)

Thank you for your Regulation 28 report dated 16th June 2017.

I understand that an inquest relating to the death of Katherine Anne Derbyshire took place on 19th May 2017. I have been fully advised of the circumstances relating to Mrs Derbyshire's death and have read your report. I am grateful to you for bringing these concerns to my attention.

I would like to take this opportunity to respond to the issues raised in your report and to advise you of the actions already undertaken by Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") and the ongoing action in respect of this matter.

I am aware that you have the following concerns regarding the care provided to Mrs Derbyshire:

1. Although Mrs Derbyshire was correctly assessed for transfer to Salford Royal for ongoing dialysis, no transfer in fact took place. By the time a bed became available on 20th December 2016, Mrs Derbyshire's condition had deteriorated to the extent that transfer could not take place. Whilst there was evidence of an active plan of management in the treatment and care of the patient as between the two hospitals, that plan did not provide for action to be taken in the event of the deterioration of the patient as observed in this case;

2. At the RAEI it would have been possible to have considered haemofiltration as a temporary measure, however the evidence suggests that this possible alternative was not considered earlier and the reason for the deferment of an alternative temporary dialysis at RAEI was the expectation of a bed becoming available at Salford Royal Infirmary. There is no evidence that the clinical needs of the patient had been triaged in a manner that effected transfer at an

appropriate stage of her treatment and care. The quality of communication between 14th and 20th December 2016 raises a fundamental issue of concern in the appropriateness of her treatment and care, in light of the fact the patient was last dialysed on 4th December 2016. There was no evidence available at Inquest as to when RAEI was informed by Salford Royal Infirmary that a bed was or would be available for the patient.

3. This case raises issues as to the nature and extent of communication between the two hospitals and the management of patients admitted at RAEI requiring ongoing dialysis treatment and care.

As you will be aware, renal care is a regionalised service with the specialist renal team based at Salford Royal Infirmary (SRFT). It may be of some assistance if I briefly set out below the chronology of Mrs Derbyshire's care and the daily discussions with the renal team at SRFT:-

12/11/2016 – Mrs Derbyshire was admitted to RAEI and diagnosed with presumed blockage and a suspected intra-peritoneal infection. Antibiotics were commenced for suspected bacterial peritonitis (as per Hospital microbiology guidelines). Plans were made to discuss with renal team at SRFT regarding the problems with peritoneal dialysis.

13/11/2016 – Mrs Derbyshire was transferred to Billinge Ward. No medical review undertaken as this was the weekend, however nursing monitoring was undertaken regularly, all Mrs Derbyshire's care needs met and her medications were given as prescribed.

14/11/2016 – Mrs Derbyshire's condition and treatment was discussed with the peritoneal sister and the renal SpR at SRFT. The renal advice was that Mrs Derbyshire did not require urgent dialysis in light of her Us & Es. The renal SpR agreed with the WWL clinician that Mrs Derbyshire required transfer to SRFT for care optimisation. WWL were informed that the SpR would liaise with the ward to facilitate the transfer; however it was noted that there were currently no beds available. SRFT advised WWL to get a CT scan given Mrs Derbyshire's drowsiness and to be careful when administering IV fluids as she was at risk of overload. This advice was followed.

15/11/2016 – Mrs Derbyshire's condition and treatment was discussed with the renal SpR at SRFT. It was advised that urgent dialysis was not currently required on the basis of Mrs Derbyshire's test results. WWL were informed that Mrs Derbyshire was on the list for transfer however no bed was currently available. The treatment plan noted to provide a daily update to the renal team at SRFT, or sooner if there were any acute changes.

16/11/2016 – Mrs Derbyshire's condition and treatment was again discussed with the renal SpR at SRFT. It was confirmed Mrs Derbyshire's observations were stable, her blood results were noted and she was not currently fluid overloaded. SRFT confirmed that there were still no beds available to facilitate the transfer, however stated that they would transfer at the earliest opportunity. WWL were advised to continue the current treatment plan and fluid management.

17/11/2016 – Again Mrs Derbyshire's condition and treatment was discussed with the renal SpR at SRFT. It was noted that SRFT still did not have any available beds, however WWL were reassured that Mrs Derbyshire was on the transfer list and would be contacted as soon as a bed became available. The renal SpR advised that Mrs Derbyshire be given oral bicarbonate, this was therefore commenced. It was noted in the treatment plan that Mrs Derbyshire may not be a suitable candidate for ICU and haemofiltration.

18/11/2016 – WWL were contacted by SRFT at around 15.30 and informed that a bed was available for Mrs Derbyshire. The ward booked an ambulance from the North West Ambulance Service (NWAS) for the transfer immediately at 15.30. Unfortunately there was a delay in the ambulance arriving on time. By the time the ambulance was available to transfer Mrs Derbyshire, WWL were informed by SRFT that the renal team would not accept the patient as it was after 9pm and so the ambulance transfer was to be re-arranged for the following morning.

19/11/2016 – Mrs Derbyshire's condition and treatment was discussed with SRFT. WWL were told that there was now no bed available for the transfer of Mrs Derbyshire and were informed that there were two other patients now on the transfer list above Mrs Derbyshire, indicating that these patients had more urgent clinical requirement for the renal beds at SRFT.

20/11/2016 – A further discussion was had with the renal SpR at SRFT in relation to Mrs Derbyshire's condition and treatment. It was noted that Mrs Derbyshire's condition had now deteriorated to the extent that she required dialysis. Unfortunately, there were still no beds available for a transfer to SRFT. WWL were advised to speak to their ICU department for consideration of haemofiltration.

Mrs Derbyshire was reviewed by [redacted] (ST7 Intensive Care) at 12.30 hours on 20 November 2016. [redacted] noted that haemofiltration would be a temporary measure and would be unlikely to have helped Mrs Derbyshire to return to her previous state. Mrs Derbyshire's condition and treatment was discussed with [redacted] (Consultant Intensivist) and with [redacted] (Consultant in Renal Medicine at SRFT) and on the basis of a risk-benefit analysis the conscious decision was taken that further renal therapy would not be in Mrs Derbyshire's best interests. The decision included consideration of Mrs Derbyshire's very poor functional baseline leading up to her hospitalisation, her poor quality of life on such treatment and the fact that she was close to the end of her life. Given the overall clinical picture, the benefits regarding the institution of renal replacement were limited, and were not likely going to increase the length or quality of Mrs Derbyshire's life.

There were also significant risks associated with the commencement of renal replacement therapy in ICU, these included the risk of haemorrhage, hypothermia and line infection. Following discussion with Mrs Derbyshire's son, the medical team at WWL and the renal physicians at SRFT on 20 November 2016 it was agreed not to institute renal replacement therapy either in ICU at WWL or at SRFT.

At 13.00 on 20/11/2017 WWL were informed by SRFT that a bed was available for Mrs Derbyshire however following the discussions as noted above, it was decided that palliative care at RAEI was the best option.

I appreciate that there were significant difficulties in facilitating the transfer of Mrs Derbyshire's care to SRFT due to the unavailability of a bed. This may have been compounded by the centralisation of services and the demands on NHS resources. However, I appreciate that this is not acceptable and did not represent the best quality of care for Mrs Derbyshire.

WWL is committed to working in partnership with other NHS Trusts to offer the best possible care to all patients. I have therefore been informed that our Medical Director, [redacted] has taken this issue forward with [redacted] the Medical Director at SRFT. There is ongoing communication between the Medical Directors to progress this matter.

A working group is also to be set up to include clinicians from both Trusts, led by [redacted] a Consultant in Acute Medicine at WWL, to prepare a pathway to facilitate the safe transfer of patients as soon as a bed becomes available and to ensure that there continues to be effective communication with SRFT.

An in-reach service is also to be implemented, this will be a service offered by SRFT where Renal Consultants will undertake 2.5 sessions of direct clinical care to in-patients at WWL every week. This will ensure that in-patients receive specialist renal assessment and treatment and will help reduce the length of stay of renal patients and free up acute bed stock faster and more frequently.

The two Trusts are also working together to implement a system which will enable the instant and electronic referral of patients to the on-call Renal team (based at SRFT). The system will allow timely advice to be provided and will ensure that all conversations between the referring Trust and the Renal Centre are clearly documented.

It is very clear from Mrs Derbyshire's records that there was a high level of daily communication with the renal team at SRFT to discuss Mrs Derbyshire's condition and treatment and to enquire if a bed was available for transfer. The Trust therefore, respectfully disputes the suggestion that the quality of communication with SRFT between 14th and 20th November 2016 raises a fundamental issue of concern. The advice of the renal team at SRFT was requested daily, the recommended treatment plan was clearly documented in Mrs Derbyshire's notes and was followed accordingly.

In response to your concern regarding the lack of evidence of a plan for the action to be taken in the event of the deterioration, please be reassured that when Mrs Derbyshire's condition deteriorated on 20th November 2016, her treatment was again discussed with the renal team at SRFT and only at this stage was the advice given to discuss haemofiltration with ICU. The Intensive Care team promptly reviewed Mrs Derbyshire and as noted above, made a difficult risk-benefit assessment to decide on the appropriate treatment for Mrs Derbyshire, following consultation with her family and all the clinicians involved in her care. Prior to this deterioration, Mrs Derbyshire's condition did not require urgent dialysis and whilst consideration was given to haemofiltration, as noted in Mrs Derbyshire's notes on 17 November 2016, it was concluded that Mrs Derbyshire was not suitable for this treatment. Mrs Derbyshire's condition was being closely monitored and the advice of the renal team followed whilst awaiting transfer to SRFT.

Continued action

As noted above significant discussions have already taken place between WWL's and SRFT's Medical Directors and the following actions will be taken:-

- A working group to create a pathway to facilitate the safe transfer of patients and to consider any further action which can be taken to avoid delays in the transfer of patients to SRFT
- 2.5 weekly in-reach sessions to be provided by SRFT renal consultants for in-patients at WWL.
- On-Call electronic service to be introduced to facilitate the instant referral of patients to the on-call team to allow timely advice to be provided.

The above actions will be monitored via the Trust's Quality and Safety Committee which is chaired by a Non-Executive Director and attended by several members of the Executive team, including the Medical Director and Director of Nursing.

I hope the above response is a testament to how seriously the Trust considers the concerns raised by Mrs Derbyshire's death. I can reassure you that WWL will continue to work with SRFT and other Trusts to try to avoid delays in transferring patients. Unfortunately however, if a patient requires transfer to another Trust for specific treatment, WWL cannot facilitate this transfer until a bed becomes available. The Trust then offers the best treatment to optimize care in the interim.

In Mrs Derbyshire's case there was an unfortunate delay in a bed being available at SRFT, the Trust therefore provided the best care they could to Mrs Derbyshire, in accordance with the advice of the renal team at SRFT to treat her condition whilst awaiting the transfer. Very sadly Mrs Derbyshire's condition deteriorated to the extent that a transfer was no longer a suitable option. Our priority then was to make her last couple of days as comfortable as possible. I pass my sincere condolences to Mrs Derbyshire's family for their loss.

If you have any comments or suggestions in relation to the proposed actions above, I would be only too pleased to hear from you.

Yours sincerely

Andrew Foster CBE
Chief Executive