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Care Quality Commission
Our Reference: [redacted]

Dear HM Coroner

Prevention of future death report following inquest into the death of Mr Dennis Allen Teesdale

Thank you for sending CQC a copy of the prevention of future death report issued following the Inquest into the death of Mr Dennis Allen Teesdale

The trust declared Mr Teesdale's death as a serious incident and the Director of Nursing reported this to CQC in a telephone call in October 2016. After reporting to us verbally, the trust also included details of the death in their monthly monitoring report for October 2016. We received this report on 16 November 2016. This read; "Major Harm Incident: ID16653. A major oncology patient developed signs of peritonitis post-surgery. The patient was transferred to BSUH and subsequently died. Care was provided at both Trusts, and the QVH investigation is underway".

Following an initial investigation, the trust's Medical Director chaired a meeting with the maxillofacial consultants on 7 December 2016 to review the events leading to Mr Teesdale's death. This included a mortality and morbidity review, which noted consultant involvement, discussion of the ultrasound scan, delay in CT scan and co-location of services discussion. At this stage, the trust reviewed national enteral feeding guidance (2015) and began to make changes to trust policies to bring it in line with national guidance, reviewed an audit of the last 10 years of PEG insertion at QVH, which determined that the trust was not an outlier

for morbidity or mortality, and began to review training standards for PEG placement.

The trust carried out a root cause analysis (RCA) investigation and agreed to share this with CQC as soon as it had been approved by the local Clinical Commissioning Group (CCG). We received this on 11 July 2017. The trust attributed the delay in sharing the RCA to delays in it being reviewed and approved by the CCG.

The trust uploaded the completed RCA to the Strategic Executive Information System (STEIS), on 23 February 2017. STEIS is NHS England's web-based serious incident management system, through which healthcare providers record incidents. It was re-submitted to the CCG on 31st March 2017, due to a change in formatting requirements, but with unchanged content. In preparation for, and during, the inquest touching on the Mr Teesdale's death, conducted by the Assistant Coroner for West Sussex on the 17th and 18th May 2017, it became apparent to the trust that the original RCA was not sufficiently rigorous to examine the care provided to the patient properly. The trust subsequently made additions to the RCA, incorporating issues raised by the inquest, concerns raised through the Section 28 Report to Prevent Future Deaths, and the reflections of staff involved. CQC's National Professional Advisor for Surgery, [redacted] reviewed the revised RCA on 18 July 2017 and described it as, "Extremely comprehensive".

We requested a number of other documents from the trust, including care records, policies and procedures, which the trust supplied willingly and within the requested timeframes. At an engagement meeting with CQC on 29 June 2017, the trust provided us with a 12-page action plan giving evidence of ongoing learning and changes to practice as a result of Mr Teesdale's death. The trust sent CQC an updated version of the action plan on 10 July 2017. We reviewed this and found it to be very comprehensive.

The trust have carried out 16 percutaneous endoscopic gastrostomy (PEG) tube insertions since Mr Teesdale's death, with two of these taking place since the inquest. The trust's lead cancer nurse is auditing all PEG insertions since January 2017 to provide assurances patients have received safe care and treatment. The trust have shared their audit tool with us, and we saw that this will allow the trust to provide assurances around areas including multidisciplinary involvement, risk assessment, and contraindications. CQC will request that the trust send us a copy of the completed audit by 30 September 2017. We will subsequently review the audit to obtain assurances of safe care and treatment.

We last inspected the registered provider, The Queen Victoria Hospital NHS Foundation Trust, on 11 and 12 November 2015, with an unannounced visit on 23 November 2015. We rated the provider as Good overall, with an Outstanding rating for the caring domain. However, we issued the trust with two requirement

notices where they were not meeting the requirements of the Health and Social Care Act (Regulated Activities) Regulations 2014. One of these related to a breach of Regulation 18(1) Staffing. The inspection report stated, "Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of the patients out of hours". This related to out-of-hours medical cover.

The trust subsequently produced an action plan to address areas for improvement. The action plan showed that the trust increased anaesthetic consultant on-site out-of-hours presence, with on-site anaesthetic consultant cover from 8am to 8pm on weekdays and 8am to 5pm at weekends. These changes were funded and described in job plans, in addition to existing on-call commitments, in July 2016.

Since our last inspection, we have maintained regular contact with the trust through regular engagement meetings and monthly quality monitoring reports. Since the monthly monitoring report for October 2016, which we received on 16 November 2016, subsequent reports did not contain any new information regarding Mr Teesdale's death. CQC receive very little direct feedback on the trust from patients, and most of this is positive. Our next scheduled inspection will take place in 2018-19 as part of CQC's national second wave of NHS trust inspections.

In response to the matters of concern raised following the inquest:

(2) *There are no facilities or clinicians (radiologist or gastroenterologists who normally undertake such procedures) available to place a PEG prior to surgery, thereby requiring oral maxillo-facial surgeons of variable and unclear experience to undertake the procedure peri-operatively.*

The trust provided us with data showing that they undertook 33 PEG insertions in the 12 months prior to the incident. The lead consultant carrying out Mr Teesdale's procedure had performed nine of the 33 PEG insertions. The second consultant assisting with the procedure had recently commenced a locum post at the trust, and this was the first PEG insertion he had assisted with since his appointment at the trust. We asked the trust how they were assured of the competencies of the locum consultant. The trust told us they had obtained assurances of the locum consultant's competencies through the application process and medical HR checks to gain evidence of previous experience. The trust told us that where these processes did not provide sufficient assurances of a consultant's competency to carry out particular work, then the consultant would complete a period of supervised practice as part of their induction. CQC's National Professional Advisor for Surgery has confirmed that no national guidance currently exists that dictates PEG insertion must specifically be carried out by radiologists or gastroenterologists. CQC's National Professional Advisor for Surgery feels it is appropriate that there is no national guidance to dictate the

specialty of medical professionals carrying out PEG insertion. He is of the opinion that competence, not specialty, is important and gave an example of a specialist nurse being trained to run the PEG service at another acute NHS Trust.

The RCA investigation stated the trust places approximately 30 - 50 PEGs per annum, and over 360 in the last ten years. The lead surgeon in this case has placed 76 of these. This is the first death directly attributable to a complication from PEG placement.

Two consultants undertake PEG insertion at the trust, with one consultant operating the scope and a second consultant inserting the trochar. The trust changed its policy following Mr Teesdale's death to ensure that only consultant-grade staff undertook PEG insertions (although the trust have informed us that two consultants carried out the PEG insertion for Mr Teesdale). For assurances around the competency and training of consultants following learning from this incident, we would respectfully refer to point (5) of this response.

Regarding the issue of the PEG being placed peri-operatively, the trust is obtaining an external review of its current PEG practices as part of the action plan following learning from Mr Teesdale's death. A review is currently being carried out by surgeons from other trusts, including a consultant gastro-intestinal surgeon. We will obtain assurances around any further changes to practice following the review as part of our routine engagement with the trust.

(3) *Written guidance by the surgeons for insertion of PEGs was not followed, with little reflection as to whether this was an acceptable procedure given Mr Teesdale's previous extensive surgery at or around the point where the PEG was inserted with concomitant poor gastroscopic trans-illumination.*

We asked the trust to provide us with the reasons consultants did not follow trust policies for the insertion of PEGs. The trust provided a detailed clinical explanation; however, they recognised that the treating consultants had failed to document the reasons for this decision in the patient notes. The trust told us the treating consultant was unaware that upper abdominal surgery was listed as a contraindication in the QVH PEG guidance.

The trust introduced a "PEG Pathway" document following learning from Mr Teesdale's death, which has been in use since 5 June 2017. We saw that this provides clear guidance to clinicians on the decision to insert a PEG. This document is to be completed for every patient having PEG insertion, and there are clear prompts and contraindications to guide consultants. The trust also revised their Enteral Feeding Guidelines in March 2017 and circulated these to relevant medical staff on 23 May 2017 following approval at the trust's Clinical Governance Group. This was to ensure all treating consultants were aware of the trust policy, including contraindications for PEG insertion.

The trust's action plan includes plans for a prospective PEG audit to provide themselves with assurances staff are following the new Enteral Feeding Guidelines and PEG guidance. This includes assurances around multidisciplinary documentation, PEG Pathway completion, consent and NPSA stickers. However, the audit is not yet in place as only one PEG has been inserted since the new PEG Pathway was introduced. We will monitor this point on the action plan through our ongoing engagement with the trust.

(4) No risk assessment was undertaken as to whether a PEG insertion would have been appropriate, given that a non-invasive alternative of a feeding tube for enteral feeding was available.

We asked the trust for a copy of any risk assessment undertaken before Mr Teesdale's surgery. The trust told us there was no risk assessment documented in the medical notes. Since this incident, the trust has developed and introduced a PEG pathway (please see point (3) for further details) and amended the enteral feeding guidance. We saw that the PEG Pathway prompts consultants to carry out a risk assessment if there are any contraindications. The trust confirmed that all consultants are expected to carry out an individualised risk assessment and to document this in the patient's notes if the PEG Pathway indicates a need for risk assessment.

Although the trust carried out two PEG insertions since the inquest, only one of these took place after they introduced the new PEG Pathway on 5 June 2017. The trust confirmed the PEG Pathway was followed for this patient. We will continue to monitor the trust's prospective PEG audit, which will capture this information, as part of our ongoing engagement with the trust.

(5) No formal 'training' programme for the insertion of PEG or independent competency based assessment

Following learning from Mr Teesdale's death, one of the points on the trust's action plan was to "explore training courses for clinicians putting in PEGs (technical skills)". There is also an action to include PEG training in trainee inductions from 31 July 2017. For trainee doctors who started working at the trust before this intake, the trust told us learning from Mr Teesdale's death has been shared at the quality and governance committee meetings, which have representation from junior doctors as well as consultants.

A further action is to obtain external oversight of the PEG service (technical and organisational), and we saw from the trust's action plan that The Queen Victoria Hospital NHS Foundation Trust is currently working with consultants from a neighbouring trust to deliver this.

CQC's National Professional Advisor for Surgery has informed us that currently, no nationally recognised training courses for PEG insertion exist. His view is that it would be very difficult to provide a comprehensive training course given that there are not large numbers of PEG tubes inserted nationally. The important aspect is that trainees are able to gain experience as available and that they do not undertake independent practice until signed off as competent. We would therefore expect registered providers to use their own competency assessment to provide themselves with assurances that all staff carrying out the procedure are competent and skilled to do so.

The trust told us that in-house training records provided assurances on the competencies of doctors trained to carry out PEG insertion by colleagues in the trust. For consultants joining from other trusts, the trust's application process and medical HR checks provided evidence of previous experience. The trust told us that where these processes did not provide sufficient assurances of a consultant's competency to carry out particular work, then the consultant would complete a period of supervised practice as part of their induction.

CQC will monitor the trust's progress against the action plan as part of our ongoing engagement with the trust.

(6) The post-operative management of Mr Teesdale did not follow the written guidance for the management of abdominal pain after PEG insertion. This resulted in a delay in seeking appropriate advice, timely intervention and optimal treatment of this complication.

The RCA investigation showed that an ultrasound scan on 18/10/2016 showed a rectus sheath haematoma, which demonstrated a potential cause of the abdominal pain. The RCA states, "This may have distracted staff from obtaining the most indicated radiological examination – a CT scan".

Following learning from Mr Teesdale's death, we saw that the trust updated its Enteral Feeding Guidelines. The revised Enteral Feeding Guidelines were approved by the trust's Clinical Governance Group in March 2017 and circulated to relevant medical staff on 23 May 2017. We saw that the revised guidelines included specific guidance on post-operative pain, with an emphasis on early escalation and transfer for CT scan. This included a warning triangle to alert doctors to this section of the guidance, with the following wording, "If there is pain on feeding, or prolonged or severe pain post-procedure, or fresh bleeding, or external leakage of gastric contents, stop feed/medication delivery immediately, obtain senior advice urgently and consider CT scan, contrast study or surgical review".

At an engagement meeting between CQC inspectors and the Director of Nursing at The Queen Victoria Hospital NHS Foundation Trust on 29 June 2017, the Director of Nursing provided assurances she had discussed in detail the

Regulation 28 Report to Prevent Future Deaths relating to Mr Teesdale with ITU nursing staff. The Director of Nursing gave reflective structured feedback to ITU nursing staff, and reported that the ITU nurses feel confident to escalate any concerns around deteriorating patients to the site practitioner and the director on call. In a follow-up engagement telephone call on 17 July 2017, the Director of Nursing was able to give an example of how an ITU sister had challenged a consultant anaesthetist and requested a CT scan for another patient. This demonstrates the confidence of ITU nursing staff to challenge consultants and escalate concerns where applicable.

We will monitor the trust's prospective PEG audit through our routine engagement. The audit will provide assurances staff have followed trust policy and escalated any deteriorating patients following PEG insertion in a timely way.

(7) Mr Teesdale's transfer was delayed because of a reluctance to transfer in the immediate post-operative period complicated by the associated logistical difficulties of doing so given his major surgery.

The RCA investigation showed Mr Teesdale's condition deteriorated around 02:00 on 19 October 2016. The RCA investigation recognised, "The decision to defer referral until the morning ward round was made with the knowledge that a transfer out of normal working hours would present a logistical challenge".

The trust's revised Enteral Feeding Guidelines (March 2017), described in point (6) of this response, address the urgent need to transfer patients when there are signs of post-operative peritonitis following PEG insertion. The revised Enteral Feeding Guidelines state the following:
"Interventions in signs of localised peritonism / pain:

- Stop feed, check length
- Clinical examination
- Blood gas, inflammatory markers
- Erect AXR/CXR
- Early review with hourly observations
- Early consideration of CT scan

Interventions in signs of spreading / generalised peritonism

- Stop feed, check length
- Clinical examination
- Blood gas inflammatory markers
- Erect AXR/CXR
- CT scan as soon as patient can be transferred safely
- Early discussion with general surgeons"

The revised guidance addresses the need to seek advice from general surgeons as early as possible and to transfer the patient for an urgent CT scan as soon as they are stable enough for transfer.

The RCA investigation showed doctors contacted Brighton and Sussex University Hospitals NHS Trust (BSUHT) in the morning of 19 October 2016, when the decision was made to transfer Mr Teesdale. The trust told us the reason Mr Teesdale was not transferred until 2.10pm the same day was because BSUHT requested that they carry out plain film x-ray and an enema on Mr Teesdale before transfer. This resulted in a delay, as the RCA reports that Mr Teesdale was in too much pain to tolerate an enema, and staff subsequently had to abandon the procedure.

The trust's adherence to their revised Enteral Feeding Guidelines, including early escalation and transfer when clinically indicated, will be monitored through their prospective PEG audit. CQC will monitor the trust's PEG audit as part of our routine engagement.

(8) As an isolated hospital, Queen Victoria Hospital has no 'on site' clinical specialist experience to assist when patients develop complications. As a consequence, there was no specialist available to assess Mr Teesdale's abdominal pain as detailed in guidance of post-operative pain following PEG insertion. No effort was made to seek such expert advice during 'daytime working hours'.

Following learning from Mr Teesdale's death, the trust has changed its practices around ITU medical staffing. At an engagement meeting between CQC inspectors and the trust's Director of Nursing on 29 June 2017, the Director of Nursing informed us that a consultant anaesthetist is now the clinical decision-maker in ITU. The provision of on-site clinical specialist expertise to respond to post-operative pain, in the form of on-site consultant anaesthetist cover between 8am and 8pm, Monday to Friday, and 8am to 5pm on Saturdays and Sundays, with on-call consultant anaesthetist cover outside these hours to assess and provide guidance on post-operative pain in ITU patients, has provided us with assurances the trust has taken action in relation to this concern to prevent future deaths.

(9) Mr Teesdale was cared for 'out of hours' by a trainee oral-maxillo-facial surgeon with unknown general surgical experience who did not recognise or manage the severity of a surgical complication.

The trust provided us with details of the out-of-hours medical staffing during Mr Teesdale's post-operative stay at Queen Victoria Hospital. These were an ST6 anaesthetics registrar (resident on-call), ST3 maxillofacial registrar on-call, (the STR registrar provided out of hours medical care to the patient). ST plastic

surgery (on-call), CT plastic surgery (resident on-call). There were consultants on-call in anaesthetics, maxillofacial surgery, plastic surgery and ophthalmic surgery.

CQC's National Professional Advisor for Surgery is of the view that, as there is no general surgeon on site, the trust should have immediate access to the appropriate advice from a general surgeon as and when required. The trust has this through their service level agreement (SLA) with Brighton and Sussex University Hospitals Trust (BSUHT). This SLA was in place at the time of Mr Teesdale's death, however, QVH staff did not escalate quickly enough. We would respectfully refer to point (7) of this response for actions the trust has taken to prevent similar delays in escalation and transfer for other patients.

(10) There was no recognition of how unwell Mr Teesdale was on the consultant surgical ward round at or around 0900 on the 19th October 2016, despite considerable evidence present at the time that Mr Teesdale had developed multi-organ failure.

The trust told us they use an S-BAR (Situation, Background, Assessment, Recommendation) tool as part of the decision-making tree in ITU. The RCA showed that the ultrasound scan findings on 18 October 2016, which demonstrated a diagnosis of rectus sheath haematoma as a potential reason for Mr Teesdale's abdominal pain. The RCA states, "This provided an unconscious bias, which prevented medical staff from considering other reasons".

The trust's revised Enteral Feeding Guidelines (March 2017), described in points (6) and (7), now address the signs of peritonitis in more detail and provide more specific guidance to staff to help them earlier detect and escalate urgent complications before they cause the patient to deteriorate further.

(11) Poor communication between nursing staff, anaesthetic staff and surgical staff making it difficult to provide an overall consistent and systematic approach to the management of Mr Teesdale in such a small High Dependency Unit with an inconsistent presence during the day.

The trust took action to ensure an increased consultant on-site presence following a requirement notice issued by CQC following our last inspection in November 2015. These actions are described in the opening paragraphs of this letter.

In an engagement meeting between CQC inspectors and the trust's Director of Nursing on 29 June 2017, the Director of Nursing told us the trust recognised that failings in communication and documentation were themes that contributed to Mr Teesdale's death. Following learning from Mr Teesdale's death, the trust included items on its action plan to improve multidisciplinary communication and documentation. These were documentation training, multidisciplinary

communication training, and an audit of multidisciplinary contribution to electronic patient records.

CQC will monitor the trust's progress against these actions as part of our ongoing monthly engagement to provide assurances of satisfactory improvement in this area.

(12) There are no haematology or biochemistry services at QVH. A courier service is required for emergency laboratory tests. This has the potential to either not request 'bloods' and/or a delay in obtaining results. Similarly, there is no 'out of hours' radiology service and there is no CT scanner on site to assist in a diagnosis (which was required as part of the management guidelines prepared by QVH).

All patients having major surgery at QVH have an individual pre-operative assessment with a surgeon. This determines their suitability for surgery at the hospital, in view of the available on-site facilities. This is recorded in the patient record.

We saw the trust's SLA with BSUH, which showed that urgent specimens are received and processed at the lab ready for testing within 1 hour of leaving QVH. This is an essential pass/fail requirement. The trust told us this target is monitored as part of monthly key performance indicators (KPIs), and the KPIs show this target has always been met. The Director of Nursing reported that the trust regularly meet with BSUHT to monitor performance in this area.

As part of the trust's action plan produced following the inquest into Mr Teesdale's death, the trust has put forward a business case for a CT scanner on site. CQC will monitor the trust's progress against this action as part of our ongoing engagement.

Should you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]

Head of Hospital Inspections