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Mr Andre Rebello
Senior Coroner Liverpool and Wirral
HM Coroner's Court
Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

12th September 2017

Dear Mr Rebello

Re: Regulation 28 Report: Paul James Maddox

This letter follows on from my letter dated 21st July 2017 in response to the Regulation 28 Report dated 19 July 2017 which was sent following the conclusion of the inquest into the death of Mr Paul James Maddox. You asked for a Trust response to the matters of concern raised within the report, the proposed actions to be taken by the Trust and a timetable for the events.

The areas of concern highlighted in your report were as follows and I will address each issue separately:

1. In spite of a Trust Root Cause Analysis Report identifying a missed opportunity before 13th April 2017 the court has been told at inquest that strategies to avoid a repeated failure were still work in progress.
2. The missed opportunity was not acting upon a reducing trend in a haemoglobin result. This is simply not good enough as this issue should have been fixed during the Root Cause analysis investigation and before the report was approved as soon as the error became evident. During the course of the inquest evidence was heard from several doctors including a surgeon and it was suggested that "when there is a downward trend in haemoglobin of 10% or more the laboratory should always ring through the result as a potential surgical emergency for the urgent review of clinicians"

The Trust acknowledges and apologises to both the Court and the Family of Mr Maddox for the delay in the implementation of the actions identified in the root cause analysis report. In order to ensure that we learn from this case and ensure that actions are implemented in a timely fashion the following actions have now been taken:

- Line management of the Legal Services Team has been moved to the Director of Corporate Affairs who will ensure that there are no out of date actions when the Trust presents to families at a future inquest. There may be occasions where actions have to be revised or reviewed, however the Trust is committed to providing the Court and the family with the reasons for this, should this be the case.
- The distress that this case caused the family of Mr Maddox has been discussed at the weekly safety summit on the 27 July 2017, led by the Medical Director, and was included in the subsequent 'Safety Bites' newsletter on 28 July that was cascaded to all staff in the organisation. This is to ensure that the Trust learns from when things go wrong.
- The case and Regulation 28 Report was discussed at both the Senior Management Team meeting and the Clinical Governance Group meetings to ensure wider learning.
- A new Serious Incident meeting has been set up and meets on a weekly basis after the safety summit to review new incidents and the progress of reports. Any issues with out of date actions can be flagged at this meeting.
- Following an external review the Trust is in the process of revising the quality, safety and governance structures in place. This will look to streamline and improve the responsibility, ownership and monitoring processes in place to improve quality and safety in the organisation.

With regards to the missed opportunity from not acting upon the reducing trend in haemoglobin results this was reviewed in detail in the Trust. As per previous correspondence it was clear from the action plan that the Lead Consultant Haematologist and our Laboratory Team had not been involved in securing a solution at an early stage.

At the time of Mr Maddox's death the triggers for acting upon a reducing trend in haemoglobin (Hb) levels was set at a threshold of a Hb level of 70g/L on first presentation, so any result below this level would result in the verifier phoning the doctor/ward team. The Trust is now aware that this level is in line with the Royal College of Pathologists guidance although this is currently under review. The Trust has a delta check in place which is a process that detects discrepancies in patient test results prior to reporting by comparing current patient values to previous ones. At the time of the death the delta review was set to flag any Hb level that falls below 25%. Time intervals are flexible with most hospital laboratories choosing 24 or 48 hour intervals, this Trust flags the most recent result.

In Mr Maddox's case, his Hb level of 95g/l subsequently falling to a level of 72g/l did not trigger the phone alert.

Actions taken following this case and the Regulation 28 report are as follows:

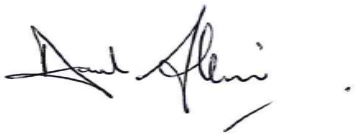
- As above this case has been discussed at the weekly safety summit on the 27 July 2017 and was included in the subsequent 'Safety Bites' newsletter on 28 July that was cascaded to all staff in the organisation
- Changes to the lab IT system have been made and an action notice has been issued to all staff informing them of the agreed changes to our standard operating procedure around Hb reporting
- The delta check value for Hb has changed from 25% to 20%. There is currently no delta check in the Royal College guidance.

- The telephone criteria for Hb has changed from less than 70g/l to less than 75g/l and continues to be audited.
- The delta check change and the telephone criteria change have resulted in the system being more sensitive to changes in patient's presentation and condition and earlier escalation.

As previously advised the Trust continues to monitor the impact in terms of improving patient safety and at present whilst escalation levels are manageable, the Trust will keep a watch in brief on the work of the Royal College of Pathologists to ensure that the Trust continues to learn from others.

Please do not hesitate to contact me if you require any further information regarding this response.

Yours sincerely



David Allison
Chief Executive