Stockport NHS
NHS Foundation Trust

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Our ref. GPo-2065
Your ref. 6680/HC

2nd November 2017

Ms A Mutch
H. M. Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Glenys POLLITT (Deceased)

Thank you for your letter of 7 September 2017 concerning the inquest of the above named patient. As always, I am grateful to you for highlighting your concerns and for providing me with an opportunity to respond.

As per your regulation 28 report to prevent future deaths, I will respond to each point as you have raised them:

1) **It was accepted during the evidence that the x ray should ideally by viewed on a high-resolution screen rather than a standard screen. This increased the likelihood of significant abnormalities being detected. There are a number of such high-resolution screens for viewing of x rays. The evidence indicated that there was differing practice across the hospital as to when such screens were used and by whom.**

   There are two high resolution screens available in the Emergency Department (ED) – one in the resuscitation room and one at the main base (where the doctors and nurses have access to multiple computers). High resolution screens are available to and used by the reporting radiologists in dimmed lighting quiet rooms. The log in to PACS (Picture Archiving and Communication System) is the same for staff regardless of what type of screen is attached to the computer terminal they are working on. The setup of images on the screens do differ which some staff may wish to have training for, which is available. ED staff are also available to support staff who are not used to looking at images on the high resolution screens whilst in ED if they are not familiar with these screens.

   The Trust's Radiology Systems Manager has confirmed that the standard screens available in ED are of a high enough resolution to view chest x ray images. The Radiology Systems Manager has drafted a document, which is awaiting their Business Group Quality Governance Board sign off, to list where all high resolution screens are within the Trust, how to access them and how to gain support to view images on them, should it be required.

   However, within our Trust serious incident investigation no member of staff stated that it was the screen resolution that impacted on their diagnosis. The root cause was found to be tunnel vision – the staff expected to see a chest infection and their likely diagnosis was confirmed by their view of the x ray. This confirmation bias led to staff not recognising the surgical emphysema on the chest x ray which in turn led to the delay of recognising the need for the patient to go to theatre.

2) **At the inquest, the evidence given was that the clinicians had seen what they expected to see on the x ray rather than seeing the whole picture shown on the x ray. It was unclear what ongoing programme was in place for reinforcing the lessons learnt from this case amongst clinicians.**

Both the Emergency Department team and the Acute Medicine team have completed morbidity & mortality discussions regarding this case – completed on 15/02/2017 and 24/05/2017 respectively. These are perfect opportunities for cases to be shared with clinicians across all grades to review and learn from a case.

Both departments have confirmed that they intend to use this case for future training of junior clinical staff in their ongoing training programmes.

3) **The process for escalation to consultant level and critical care was unclear.**

During the evidence at the inquest it was confirmed that the Trust were using the Early Warning Score Escalation Pathway (EWS). At 04:39 07/02/2017 the patient was scoring an EWS of 6 (based on the EWS pathway parameters). The pathway states a middle grade should be contacted to discuss the patient's management and to review the patient if clinically indicted. On this occasion it is document in the ED record that the patient was being reviewed by the medical registrar at 05:15. The EWS pathway says to consider ICU referral for EWS = 5 to 7, it does not state a definite referral.

During the inquest the patient's daughter asked why the Trust used the EWS pathway not the National Early Warning System (NEWS) as she believed the patient would have been escalated to the critical care team sooner based on the NEWS pathway. The evidence given in response was that though we were not using NEWS we had intended to change to it from 30/09/2017 when our new electronic patient record (ePR) was launched. Unfortunately this launch has been delayed and we do not have a definitive new launch date. Therefore our Assistant Director of Nursing, who has been tasked with rolling out NEWS across the Trust, is currently working up an implementation plan that is not reliant on the launch of our ePR.

The NEWS would prompt consideration of escalation to critical care if the patient scored a 7 or higher. On review of the patient's observations in the Emergency Department, based on NEWS, the patient would have triggered for consideration of transfer to critical care at 01:54, 07/02/2017. On the assumption that critical care would have attended following escalation at that time, it is probable that the patient would have been planned for surgery as it is likely a CT scan would have occurred sooner.

I hope that this response addresses your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients. Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely

Ann Barnes
Chief Executive