Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

PRIVATE & CONFIDENTIAL
Mr Heming
Her Majesty's Coroner
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Date: 18 October 2017

Dear Mr Heming

Sam Antony Crick, Deceased

I am writing in response to your Regulation 28 report dated 25 August 2017, following the inquest hearing into the sad death of Mr Sam Antony Crick.

In your Regulation 28 report you sought reassurance in relation to issues surrounding the neurosurgical management of Sam Crick at Queens' Hospital (the 'Trust'); 5 areas of concern were highlighted which I address in turn, below.

A. Lack of a Serious Incident Report (SIR) into the death.

Trust Response

An SIR was not initially triggered in this case as the Trust was not notified of Sam Crick's death. The Trust only became aware of Sam's death when , Consultant Neurosurgeon wrote to the family to investigate why the patient had not attended a clinic appointment with in May 2016.

It is normal practice for the Division to discuss all deaths at the Trust within 30 days of death and where indicated to notify of a potential SI in accordance with the Trust's Incident & Serious Incident Policy. At the time of Sam's death the Trust had no process to review externally reported deaths. This will be addressed in the SIR with a recommendation that all externally reported deaths are reviewed weekly as part of a Morbidity and Mortality session to identify any lessons and feedback to referring hospitals.

Following receipt of the Coroner's Regulation 28 report a Significant Incident (SI) notification was completed by the Division and an SI declared by the Trust's corporate team on 31 August 2017. SI investigations are currently ongoing and the report will be shared with the Clinical Commissioning Groups (CCG's); Barking, Havering and Redbridge Clinical Commissioning Group (BHRCCG) and North East London Commissioning Support Group (NELCSU) on or before 23 November 2017. The CCG's then has 20 days to consider the report and agree the findings.

Once the report has been agreed by the CCG's the report will be shared with the family.

The Trust will implement an action plan in the timescale agreed in the SIR, based on the lessons learned from this case.

B. The neuro-radiological review of the CT scan in November 2015 and early December 2015 did not highlight the obvious brain parenchymal herniation through the re-existing burr hole as well as other interval change and this was a missed opportunity of flagging a clear indicator of rising intracranial pressure.

Trust Response

The neuro-radiological review of the CT scans in November 2015 and early December 2015 did not highlight the brain parenchymal herniation through the re-existing burr hole as this finding was missed. This is a an exceptionally rare complication; the Neuro-radiologist who reported the scan and who has 17 years of experience as a Consultant Neuro-radiologist has never previously encountered this complication.
The Trust acknowledge this finding was missed by the reporting Neuro-radiologist but does not accept that the finding was 'obvious' as suggested.

The worsening hydrocephalus and raised intra cranial pressure were both documented on the 26 January 2016 imaging and reported on 4 February 2016. The further subtle finding of the herniation, were not noted.
The ongoing SIR investigation will include recommendations on improved management of patients with known, high, raised intercranial pressure including clear guidelines on how to escalate concerns and the development of a Rapid Review Access Clinic to enable appropriate triage of patients.

C. The last face to face consultation between the neurosurgeon and Sam was on 03.02.16 but the written neuro-radiological report of the 26 January 2016 CT scan was not available until 4 February 2016 so this report was not considered by the neurosurgeon as it was not available for this key consultation. This report did highlight some alarming features of herniation but this vital information was therefore not considered (prior to Sam's appointment on 3 February 2016)

Trust Response

Responsibility for following up imaging requests rests with the requester and the Trust accepts that in Sam's case, the imaging was not available for his clinic appointment on 3 February 2017 as it should have been.
In reviewing radiology processes the Trust has identified the need to improve the quality of radiology requests. On 17 August the Medical Director cascaded to all clinical staff a set of standards expected of clinicians in making a radiology request. A copy of the email dated 17 August 2017 is attached for your information.

D. The neurosurgeons examination on 02.12.15 did not find frank papilledema yet an examination by a consultant ophthalmologist at the Luton and Dunstable hospital on 18 November 2015 and 24 December 2015 had found papilledema at both appointments. The consultant neurologist's referral letter from Luton

and Dunstable indicated a finding of papilloedema also and stated an ophthalmic review was being sought but there appears to have been no attempt to find out the outcome of the Luton's assessments. Further, and in the alternative, no specialist ophthalmic advice was sought by the neurosurgeon even though there had been lengthy ophthalmic follow up over a number of years after the third ventriculostomy in 2007 and also given the recorded findings of the consultant neurologist in Luton.

Trust Response

The Consultant Neurosurgeon involved in these examinations is no longer practicing in the Trust and is therefore unable to personally comment. These failures are however, being investigated as part of the ongoing SIR and recommendations will be made to ensure that these issues do not happen again.

To BHRUT and the CQC

E. **There have been a number of Regulation 28 reports issued by Nadia Persaud, Senior Coroner for the area of Eastern Area of Greater London raising concerns over a number of clinical deaths. In addition , a CQC inspection in September 2016 and October 2016 (report published in March 2017) have made findings of the Trust 'requiring improvement' in a number of respects when measured against key standards. The CQC report published in 2013 referred to a previous mortality alert concerning septicaemia shunting in hydrocephalus where the hospital review found no obvious deficits in clinical or operative quality. This inquest was an independent review where expert evidence exposed shortcomings in the management of hydrocephalus. It is not clear whether the circumstances of this death were disclosed during the most recent inspection.**

Trust Response

The circumstances of this patient's death were not disclosed during the most recent inspection by the CQC as this information was unknown at the time; routine disclosure of individual patient deaths is not a CQC requirement.

Since April 2017 all Trusts have been required to collate and publish quarterly information on deaths in accordance with National Guidance on Learning from Deaths. The Trust has developed a 'Learning from Deaths' policy in accordance with the national guidance which sets out how the Trust responds to and learns from, deaths of patients who die under its management.

The Trust is committed to continuing to learn from Inquests. Please let me know if you require further information.

Yours sincerely

[redacted]

Dr Nadeem Moghal
Executive Medical Director

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