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NHS
Northern Care Alliance
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Salford I Oldham I Bury I Rochdale I North Manchester

Ref: PD/lb

19 April 2018

Group Director of Patient Safety
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Telephone:

Strictly Private & Confidential

Ms Rachel Galloway
Assistant Coroner
Coroner Area Manchester South
1 Mount Tabor Street
Stockport
Cheshire
SK1 3AG

Dear Ms Galloway

Re: Barbara Johnson

Thank you for your letter dated 21 March 2018 enclosing a Regulation 28 Report in respect of the above deceased.

The Trust was unfortunately unaware of this inquest until receipt of your letter. I note you are concerned that junior doctors working at Trafford General Hospital routinely ignored the printout of an ECG which was not considered and/or used to form clinical interpretation and judgement.

I can advise that whilst the two junior doctors concerned were technically employed by Pennine Acute NHS Trust, who are the administrative lead employer for all junior doctors across Greater Manchester, Cumbria & Lancashire, they were placed at Tameside General Hospital who acted as the Host Trust. The Host Trust is responsible for the quality of care delivered to patients and direct supervision of a trainee on a day-to-day basis. Pennine Acute Trust, as the lead employer, are simply the administrative employer of the junior doctors, having responsibility for HR issues such as pay and sick leave, but are not responsible for the quality of training and care at a Host Trust.

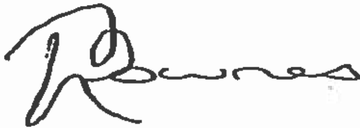
As such, I would suggest that Trafford General Hospital were responsible for the quality of the care provided to Barbara Johnson, and for the quality of care and direction supervision of the junior doctors. Therefore, Pennine Acute Trust is unable to implement change at Tameside General Hospital and we request that the Regulation 28 Report is amended and addressed to Tameside Hospital, who have the power to take action to address the concerns within your report.

I would also like to respectfully refer to the Chief Coroner's Guidance No.5, paragraph 11, which states that a Regulation 28 report should only be sent once *"the coroner has considered all documents, evidence and information"*. It further states a coroner has a duty to report the matter to the organisation who has the power to take action, as per paragraph 10(5) of the guidance. In future, if there are any concerns regarding this organisation, please could you or your officers make contact with [redacted] Head of Legal Services, so that the Trust has an appropriate opportunity to present evidence and submissions as is envisaged by the Chief Coroner's Guidance.

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

I look forward to hearing from you.

Yours sincerely



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Group Director of Patient Safety