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Date: 18 June 2019

Dear Mr Ellery

Re: Regulation 28 Report - Mark Richard Hinton (deceased)

I write in response to the Regulation 28 Report issued on 30 April, 2019. For ease of reference, I will respond to the Coroner's concerns following the numbering pattern within the Regulation 28 Report.

1. The Information Chain

a. When Mark (as the family wish him to be referred to) attended A&E he informed the triage nurse (nurse A) that he had contacted 111 who advised to go to A&E due to possible 'clot'. That information was not recorded or passed on to others. Recorded examination of Mark included pain and obvious swelling to right calf.

There is nothing in the Trust documentation that the information provided to 111 was subsequently provided to the Trust.

b. The Staff Nurse (nurse B) who then carried out observations on Mark came to the view that he 'could probably do with a D-Dimer'. That nurse states she passed that information to the next (third) nurse (nurse C).

This is agreed as contained within the statement of Nurse B.

c. Nurse C states that information was not passed to her. She was unaware that Mark had pain in his calf and therefore had no reason to request bloods, particularly a D-Dimer test, and had no knowledge of them being requested.

Nurse C states that the information was not passed to her, and therein lies a discrepancy in evidence.

d. At or around 19:33 hours it appears that bloods, including a D-Dimer test were requested. However there is no record of these (8) test being recorded or who ordered them or why.

When a patient presents to ED, the reason for admission would determine which blood tests are carried out. There is no record of the D-Dimer test being requested on the ED card, however, the results are on the Review system. The Review system does not show which tests are requested, only the results. Interrogation of the pathology systems confirmed that the D-Dimer test was requested under the computer log-in of Nurse C.

e. When the attending doctor first saw Mark at 21:06 hours he saw the results of 7 blood tests none of which indicated to him the presence of a possible DVT. The 8th blood test (i.e. the D-Dimer test) was not shown and as there was no record of it having been requested he did not know it was outstanding and nor in his opinion, was it required. Upon the information before that doctor he medically discharged Mark from hospital. Following Marks' discharge from hospital the result of the D-Dimer test became available which would have led to Mark being admitted with treatment which probably would have saved his life.

The treating Doctor reviewed Mark at 2155 hours and wrote in the records at that time. The ED system shows that Mark was discharged at 2210 hours. The Review system shows that the D-Dimer results were available at 2205 hours, 5 minutes before Mark was discharged. However, as the treating Doctor did not know that the D-Dimer test had been requested, he had no reason to go back and re-review the blood tests. The records show that Mark was keen to go home even without medication.

2. **System Failures**

a. The system did not require or mandate the person who requested blood tests, specifically in this case a D-Dimer test, to record that request or the reason for it. There was no alert system which would have alerted the final decision maker of that request. At that time a health care assistant, staff nurse or doctor could have requested the tests. Only a doctor may do so now.

There is a facility to alert clinical staff to tests that have been requested [Appendix 1, CAS card, page 2]. This section of the CAS card was not completed, due to human factors, not a system failure.

In relation to who can request a blood test, the current system is that any trained clinical professional may request a D-Dimer test once it is authorised by a doctor.

The electronic system does not indicate how many tests have been requested, but will only report on the outcome of the tests.

b. The evidence indicated that agency nurses and locum doctors did not have access to the hospital systems in particular the "review" system for requesting and reporting on tests. It appears to have been common practice for those who could not do so to log on using a permanent member of staff's pin number or access code, with or without their permission. The blood tests had been requested on nurse C's 'review' account who denied doing so.

The Trust IT policy (Information Governance guidance) stipulates that personal PIN numbers/log-ins must not be shared and individuals sign to adhere to this policy. It is an individual's responsibility to log out once immediate work is completed.

To reinforce information security, in ED there is a "lock out" after five minutes on a personal log-in.

Locum staff and agency staff do not have a generic PIN as that offers a compromise to information security.

c. If none of the witnesses who gave evidence requested the D-Dimer test it meant that another person did and could do so without any entry or note made in the A&E records.

Accepted. There is no definitive explanation as to what happened. However, it is possible that another person used Nurse C's log-in before it locked out.

3. **Other Matters Arising**

a. A second set of observations should have been made before Mark was discharged. This did not happen.

This is accepted. A second set of observations should have been taken which is good practice. This has been a learning point for the individual doctor.

b. The D-Dimer test result was delayed due to a systems error with the CS2500 machine. It is stated that this may happen intermittently and is then corrected. Had the system error not occurred it is likely that the (8th) result would have been available on screen for the discharging doctor to review.

Yes, this is accepted and a full explanation was provided in the evidence by Dr E.

c. Telephone results are not made if the patient is an in-patient in A&E. The Standing Operation Procedure (SOP) in Pathology states "D-Dimer greater than 500ug/l telephone to GP, out-patients and outlying hospitals (excludes SATH in-patients)". Is a patient waiting assessment in A&E an out-patient or in-patient or some other category?

A patient in ED is an "in-patient", therefore the protocol is that the Pathology Department do not telephone through the results as they will be available on the system. The onus is on the requester to check the results. The normal standard within Pathology is that the Pathology Department rings up to three times for some abnormal test results, for example, Hb, low potassium. Thereafter it defaults to the requester to check the system.

There are no national guidelines in relation to D-Dimer tests, it is up to the individual Trust to determine. There are no guidelines from the Royal College of Pathologists which is what we take other ranges from to action.

d. Differential diagnosis. Had all the information been available to the discharging doctor a differential diagnosis of DVT may have been made and recorded.

Accepted.

e. A body map had not been completed at any time.

Mark was classified as a "minors" patient. A body map is used for significant skin disorders, for example, pressure sores, lacerations, bruising. Patients who are classified as "majors" would by definition have a body map completed.

f. Oramorph was recorded as having been given but not checked. Also it may mask symptoms of pain.

There was no documentation as to why Oramorph was prescribed, however, there was a pain score of 10/10 which would justify a painkiller like Oramorph. There is no pharmaceutical requirement for Oramorph to be double-checked.

g. Whilst D-Dimer tests were becoming routine rather than clinically required, Mark had come in with a possible 'clot' whether his earlier symptoms had improved or not.

The Trust did not know about the suspicion of a clot which we understand, with hindsight, to have been suggested when Mark sought primary care advice (1a). Mark's presenting complaint was a painful leg which was not necessarily indicative of a clot.

h. The absence of documentation made it difficult if not impossible to resolve factual discrepancies between members of staff.

Agreed. The Trust relies on the integrity of individuals to maintain professional standards of completing documentation. There are clear guidelines issued by both the NMC and the GMC which should be adhered to. An action from the RCA was to audit whether the ED staff were compliant in completing documentation. The initial audit results showed poor compliance and the plan is for the audit to be repeated monthly. The results have been discussed by the senior ED management team who are tasked with bringing improvement.

i. The impression given by witnesses was that they were under pressure (racing against the clock) to meet the 4 hour deadline in A&E.

The ED was routinely busy. On 8 October, 2018, the data shows that the "majors" side of ED was very busy, and these patients have clinical priority. Therefore patients within "minors" tend to have a longer wait. The "four hour deadline" refers the time the patient is seen and discharged home, seen and the decision is taken to admit. In Mark's case, he arrived at 1637 hours, he was triaged at 1725 hours, ECG at 1752 hours, Oramorph given at 1930 hours, bloods at 1933 hours, seen by the doctor at 2106 hours, and discharged at 2210 hours.

Patient safety overrides any national targets imposed.

I hope that the above provides assurance that the Trust has taken action to implement the lessons learned from this sad case. If you require any further explanation, particularly in relation to the systems or processes within ED or Pathology please do let me know.

Yours sincerely

Simon Wright
Chief Executive