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Private & Confidential
Mr T R Holloway
Assistant Coroner Blackpool & Fylde
PO Box 1066
Corporation Street
Blackpool
FY1 1GB

Dear Mr Holloway

Re: Regulation 28 report relating to an inquest into the death of James David Fletcher

I write on behalf of the Trust in response to your Regulation 28 report following your inquest into the death of James David Fletcher. The Court reached a narrative conclusion and had six matters of concern which I shall address in turn.

1) **There may be a lack of disseminated guidance and protocols for the care of those patients who are unable to communicate verbally** – The Trust has an Accessible Information Standard Policy allowing for production of information in different languages and formats, including braille. Our Interpretation and Translation Procedure caters for service users who do not speak English or who are hard of hearing. The Trust has two further relevant guidelines, one for the care of people with learning disabilities and the second for the provision of learning disability adapted dementia screening. The first of these was instituted in May 2016 and is currently being reviewed and revised. Within our Emergency Department Blackpool residents are flagged on the electronic patient record if they are known to have learning disabilities thus alerting medical and nursing staff. These alerts automatically populate the electronic patient tracker for those patients who are admitted from the Emergency Department to our Acute Medical Unit. The Trust is currently working with the Data Controller for Fylde and Wyre CCG so that we may introduce a similar flag for Lancashire residents in our catchment area. Within the Trust we have a lead nurse for learning disability who is available to all staff for advice on the care of patients with learning disabilities and we have a programme for Learning Disability Guides who are link members of staff within the different areas of the Trust. This familiarises them with our current guidelines and sources of further information.

2) **Concern regarding record keeping** – Whilst the Trust has made progress with electronic access to general practice records and partial provision of electronic records within the Emergency Department we have not as yet implemented an Electronic Document Management System (EDMS). A business case was approved by the Trust Board in January 2018 but because of more pressing cost pressures it has not been possible to progress this to date. A revised business case is in development and due for consideration by Executive Directors by the end of this month.

3) **Accuracy of communication between medical and nursing staff** – The Trust recently introduced a revised early warning score NEWS2 which is a national programme for the recognition of patients who require assessment. There has been a training programme overseen by the Interim Director of Quality Improvement and the Deputy Medical Director to ensure that all staff are aware of this. The above two officers jointly chair the Care of the Acutely Ill Patient workstream within the Trust and have oversight of the roll-out of the training programme. In addition the Trust has a SBAR tool to convey important information between clinicians when patients are being transferred from one area to another area when review of a patient is required.

4) **A lack of knowledge about risks of peritonitis in patients who have undergone PEG surgery** - As identified in the Serious Incident (SI) investigation report signed off by the Chief Executive in December of last year a death after PEG tube insertion is rare and occurs in less than 1% of procedures and peritonitis too is a rare complication. That notwithstanding, staff should be alert to the risk of peritonitis in any patient who has undergone abdominal surgery and I have issued a Red Alert to all staff in the light of this serious incident investigation to remind them of: vigilance in the post-operative period and of the need to be alert to the possibility of peritonitis; and guidelines on the care of PEG tubes.

5) **Risk of peritonitis may be shrouded by risk of sepsis and aspirational pneumonia** – It is a clinical fact that in patients who are septic it is often difficult to identify the cause of their sepsis. In Mr Fletcher's case his most likely source was initially thought to be pneumonia. I hope that actions arising from the Red Alert mentioned in point 4 above will address this concern.

6) **Approximate availability of essential medication** – The practice in the Trust is that all patients on admission have their medication reviewed by the admitting doctor and are then seen by a clinical pharmacist and drugs are prescribed for use within the Trust.

Yours sincerely

PROFESSOR MARK O'DONNELL
MEDICAL DIRECTOR