Manchester University
NHS Foundation Trust

Joint Group Medical Directors' Office
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Ms J Harkin
HM Assistant Coroner
HM Coroner's Office – Manchester City Area
Manchester City Coroners' Office & Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester M2 7EF

Sent via email to: coroners.office@manchester.gov.uk

Dear Ms Harkin

Re: Mr Peter Carroll – Regulation 28: Prevention of Future Deaths

Thank you for highlighting your concerns in respect of this case, which I have now had the opportunity to look into. The response required from Manchester University NHS Foundation Trust is in relation to the following:

- no leading physician signing off reports
- concerns re 6 month delay in reporting

With regard to the responsible physicians signing off Histopathology reports; since this incident, processes in both Histopathology and the Department of Surgery have been strengthened.

In the Department of Histopathology, measures have been instituted such that in the event of apparently unexpected or metastatic malignancy in a specimen from a site outside the pathologist's area of expertise, that case is redirected to another pathologist who specialises in that field. All confirmed cancer cases are listed for discussion at relevant multidisciplinary team meetings (MDTs). In the case of delay or inability to discuss in the appropriate MDT, pathologists/pathology administrative staff have been instructed to email the report directly to the responsible clinician. In addition, a printed report marked 'Urgent Report' will be sent to the responsible clinician.

The Royal College of Pathologists issued guidance in October 2017 in relation to the communication of critical and unexpected pathology results (Document G 158 – which is the Royal College of Pathology document number that describes the process when there is unexpected pathology – enclosed as attachment).

MFT Pathology team have confirmed that the process for managing pathology results has been updated following this investigation and in line with the guidance that all histology samples confirming cancer diagnosis are directed to the appropriate cancer MDT.

Within General Surgery, as part of the actions relating to this investigation, the team undertook a review of the administration processes in relation to histopathology paper results. The provision of paper results currently provides a backup assurance system to the electronic process. It was confirmed by the Administration Manager on 27 April 2017, that as part of this review into Mr Carroll's case, all histology paper results are now date stamped upon arrival into the department

and added to a tracker. An outcome form is then attached to the histology result that requires the requesting consultant to review, action and sign off with immediate effect and this is then updated on the tracker. The administration team monitor the tracker on a monthly basis to ensure the outcome is completed.

A summary of the investigation and the learning was shared formally across the Division at the Surgery Clinical Effectiveness Group meeting on 20 April 2018 to ensure that all surgical teams had effective processes in place to deal with similar histopathology reports.

The investigation also found that another factor in this incident was that the Discharge Notification Form (DNF) did not report that a biopsy had been taken. Whilst Mr Carroll's operation note was available electronically to view on the theatre ORMIS electronic record system in October 2016, at that time it was necessary for clinicians to undertake a separate log-in to access operation notes when DNFs were being completed. This process has been strengthened from April 2017. MFT Chameleon Electronic Patient Record (EPR) system improvements have facilitated the inclusion of operation notes thus creating a single electronic record source to access operation notes when DNFs are being completed hence reducing the possibility of similar omissions, due to the need to refer to multiple sources of information.

A further plan to improve communication of test results is currently being implemented at our Oxford Road site. At the Wythenshawe site of MFT, we introduced a fully electronic paperless system of reporting test results to requesting clinicians, which facilitates electronic results acknowledgement and allows tracking of clinician performance in reviewing results. We are currently introducing a similar system within the Chameleon EPR at Oxford Road site.

The investigation outcome concluded that it was not possible to ascertain with any certainty whether the 6 month delay in reviewing Mr Carroll's biopsy results impacted negatively upon his treatment plan, or indeed influenced his prognosis. However, we sincerely apologise to Mr Carroll's family for this delay and any additional distress arising from it.

Please accept my assurances that lessons have been learned from this case and appropriate actions have been put in place to address the issues raised. If you require anything further then please do not hesitate to contact me.

Yours sincerely

[redacted]
Joint Group Medical Director

Encl.