HER MAJESTY'S CORONER
For the West Yorkshire (Western) Coroner Area

The Chief Coroner,
Rule 43 Reports,
Chief Coroner's Office,
11th Floor, Thomas More Building,
Royal Courts of Justice,
Strand,
LONDON. WC2A 2LL

Our ref:MDF-HK/2471-2018

27th September 2019

Dear Sir,

Re: Gladys May Sayles, deceased
Report to Prevent Further Deaths
Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and
Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

Please find enclosed a copy of a response report received from The Leeds Teaching Hospitals NHS Trust.

Yours faithfully,

M.D. Fleming
Senior Coroner
West Yorkshire - Western

Enc.

MF

Ref: Enquiry into the death of Gladys May Sayles
DOB: 05/08/1928 NHS No: 4748684933
Date: 5 September 2019

NHS
The Leeds Teaching Hospitals
NHS Trust

Private & Confidential
Mr M D Fleming,
Senior Coroner
West Yorkshire (Western) Coroner Area
City Courts
The Tyrls
Bradford BD1 1LA

Trust Headquarters
Leeds Teaching Hospitals Trust
St James's University Hospital
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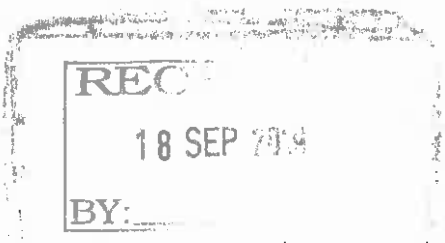
LS9 7TF
www.leedsth.nhs.uk



In the matter of an enquiry into the death of Gladys May Sayles RE: regulation 28 report

Dear Mr Fleming,

Thank you very much for your letter dated 3 September 2019. In your letter you indicated that you were invited by representatives from Calderdale and Huddersfield NHS Foundation Trust and the family to ask that Leeds Teaching Hospitals NHS Trust be incorporated into the Regulation 28 report. This is in respect of the effectiveness of the existing communications between Leeds General Infirmary Neurosurgical Unit and Huddersfield Royal Infirmary. The Regulation 28 report also refers to the fitting of collar and the patient's general care. In your letter you invite us to reconsider the current systems of communication between ourselves and referring hospitals such as Huddersfield Royal Infirmary.

I have now had the opportunity to review the communications between the referring team and the on call Neurosurgical Team. I note from the detailed records that the first contact was made by [redacted] at Huddersfield at 14:54 hours on 21 September 2018. A response was sent at 17.42 on the same day by [redacted] with advice that the cervical spine CT showed significant rotation and displacement of a fractured bone fragment. [redacted] inquired about the patient's neurology and agreed to discuss this with the on call consultant. At 20.47 [redacted] again contacted Huddersfield Royal Infirmary confirming that the images had now being reviewed by the on call consultant and the operative care was not indicated. The treating team Huddersfield Royal Infirmary were advised to manage the injury with a neck brace.

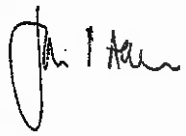
Without further prompting [redacted] contacted the clinical team at Huddersfield again on the following morning at 09.48. This was following a further review of the case and imaging at the morning handover meeting. The advice remained the same that conservative and supportive care was indicated and that the patient could be managed locally in Huddersfield. Further contact was made on the 2 October 2018 at 11:54 when the referring team sought an update on the management plan. Unfortunately the images were not sent electronically and the team at Leeds responded at 13:17, including a request for the scans. The images were sent across

at 11:35 on the following day 3 October 2018. This was at 11:35 and there followed further communication between the two teams at 12:34, 15:53 and 17:36 the same day. It remained clear that Mrs Sayles was not a suitable candidate for operative intervention and that continued best supportive care at Huddersfield would be sensible in the circumstances. I was saddened to hear that Mrs Sayles had not recovered and subsequently died.

Having reviewed the communications between the referring team and the Leeds Neurosurgical Unit, I have come to the conclusion that the discussions were had in a timely fashion and that the appropriate advice was given. It is recognised that an electronic system such as this can be somewhat frustrating for the referring team but it does allow for robust data capture and to ensure a proper audit trail. I am satisfied that the current arrangements are appropriate and responsive.

I hope you have found this reassuring but I would be more than happy to provide any further details if you felt that was necessary.

Yours sincerely



[redacted]
Associate Medical Director (Risk Management)