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NHS Foundation Trust

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Private and confidential
Mrs M Jones
HM Assistant Coroner for Stoke –on –Trent & North Staffordshire
547 Hartshill Road
Hartshill
Stoke on Trent
ST4 6HF

26 July 2019

Dear Madam,

Re: Regulation 28 report to prevent future deaths following the inquest touching upon the death of Mr Geoffrey Duke

I am writing in response to your Regulation 28 Report dated 30th May 2019 following the inquest touching upon the death of Mr Geoffrey Duke.

I understand that during the inquest you identified concerns arising from the absence of a referral process for patients who have undergone pacemaker surgery who become unwell. It was identified that there was no referral to a cardiologist which led to a failure to identify that Mr Duke had become unwell due to an infection associated with a pacemaker insertion. I would like to begin by offering an assurance that the Trust has taken steps to address the issues that you have identified, to ensure that there are mechanisms in place to prevent this occurring in the future.

The Trust has implemented the following actions to ensure appropriate identification, diagnosis and referral to a cardiology specialist for patients who have a suspected infection following a pacemaker insertion:

I can confirm that the enclosed (appendix 1) Cardiac Implantable Electronic Device Lead Infection Microbiology Hospital Guideline has been developed by the Antimicrobial Pharmacist, Cardiology Consultants and Microbiology Consultants. The document provides guidance on the detection and treatment of Subacute Bacterial Endocarditis (SBE) related to cardiac rhythm devices. This is now subject to the Trust's governance process to formally sign the guidance off.

Once formally signed off, this guidance will be linked to the Trust's existing guidance for Pyrexia of Unknown Origin (PUO) as guidance for patients presenting with pyrexia (temperature) of unknown origin with a cardiac rhythm device in place.

The final draft and final signoff in conjunction with a communication plan will be complete by 30th September 2019. Once sign off has been completed, the guidelines will be accessible to all staff through the Trust's intranet (called 'Flo'). In addition, the Divisional Medical Director and Divisional Nursing Director will ensure that this information is disseminated to all the Clinical

Directors within each of the Trust's divisions, and tabled at their medical meetings with clinical staff.

The development of this guideline supports the previous learning board shared with all Doctors in the Department of Medicine and the discussion at the Acute Medicine Mortality meeting in May 2019, in raising awareness with the relevant teams. For ease, I have also enclosed a further copy of the learning board (appendix 2), Statement of [redacted] (appendix 3) and SI report (appendix 4) to confirm the steps that the Trust is taking.

This will be further supported at the Trust-wide Quality Summit on 26 September 2019 where [redacted] with discuss this case and the learning that has been undertaken. It is hoped that aspects of the summit will be captured on videos and podcasts that will be available on Flo. Finally, [redacted] will also highlight this learning within his monthly 'Patient Safety Brief' newsletter (August 2019) that is sent to all staff to further highlight the guidelines and the learning following this case.

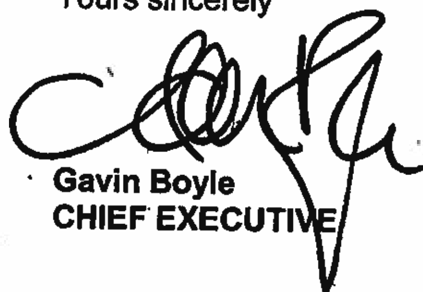
Conclusions

The Trust has shared the learning from the inquest with the department of medicine to raise awareness. This has been supported by a review of the guidance available to clinicians, within the Organisation, relating to the identification and diagnosis of infection associated with a cardiac rhythm device. Following this review guidance has been developed and will be linked to the guidance relating to pyrexia of unknown origin.

I trust that you will be satisfied that these changes have addressed the issues that you identified. The Trust would very much welcome your feedback on the changes that have been made to strengthen the care and management of patients with infection associated with cardiac rhythm devices.

Please do not hesitate to let me know if you require any further information from the Trust.

Yours sincerely



Gavin Boyle
CHIEF EXECUTIVE