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29th May 2018

Mr Zafar Siddique
Senior Coroner, Black Country Area
Black Country Coroner's Court
Jack Judge House, Halesowen Street
Oldbury
West Midlands
B69 2AJ

Dear Mr Siddique

Response to the Regulation 28 Report – the late Mr Frank Hayward

I am in receipt of your Regulation 28 Report following the Inquest and your ruling on 9 March 2018, in respect of the late Mr Frank Hayward.

We take our incidents very seriously and as such I and the Board are sited on the issues related to caring for patients with Head Injuries. This letter details what we have already done and what is planned to do to change and improve practice.

The guideline used by clinicians to inform diagnostic testing and treatment of Head Injuries has been revised in line with the latest National Institute for Excellence (NICE) Clinical Guideline (CG176). Our guideline includes an algorithm of when to image the spine and the head injury proforma now includes a checklist for both head and neck imaging as a further prompt. This proforma was traditionally only used in the Emergency Department (ED), but will now be a requirement for all clinicians to use on any patient who sustains a fall in hospital as well as those who present to the ED. Equally the guideline will apply to anyone who has sustained a head injury, providing consistency with referrals and observations.

The revised draft guideline was recently shared at our Quality Improvement Half Days on 16th May, asking teams and specialties to take note of the requirements of the guideline and to highlight any challenges they see in implementing the changes and providing any solutions. The output of everyone's sessions are being collated and shared with the Medical Director, Dr David Carruthers. We clearly need a guideline that provides for patients such as Mr Hayward, but need to balance this with any changes required to services to ensure this provision is possible. Dr Carruthers will ensure that the approved guideline is adopted within the next month, with plans to meet any specific challenges.

Clinicians from Trauma & Orthopaedics have, since this incident, been trained in the application of Miami J collars, enabling patients to be fitted out of hours in future. A stock of Miami J collars is held on our T&O ward (Newton 3) and this is checked and replenished daily by the Orthotics team.

At the time when Mr Hayward required a collar, the Orthotics Department was in the process of relocating onto the Sandwell General Hospital (SGH) site. This move, together with issues of transfer of telephone numbers and locum staff, delayed the referral being received and acted upon. All wards at SGH now have the contact details (number and email address) of the Orthotics Department to ensure contact is timely, with substantive administrative staff in place. Business Continuity plans are in place but are being reviewed to take account of staffing levels, given that this was a concern at the time of Mr Haywards admission.

We will monitor the use of the approved Head Injury guideline following a period of implementation, but in particular we will be ensuring that:

- Imaging is carried out at the right time and on the right patients
- Patients who have sustained a head injury are observed for the correct period of time
- Referrals to specialist advice are made and actions requested followed through

I am satisfied that our response will address the concerns which were apparent both from our own internal investigation and which you have raised.

My colleague, Allison Binns, Deputy Director of Governance, is best placed to provide advice or further details on our actions, or indeed updates on the progress moving forward. She can be contacted on 0121 507 4121 or through allison.binns@nhs.net

Yours sincerely



Toby Lewis
Chief Executive

cc Family of Mr Hayward:

[Redacted contact information]