Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

**EXECUTIVE MEDICAL DIRECTOR**
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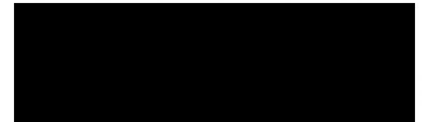

30th June 2021

**Andre Rebello**
**Coroner**
**Liverpool and Wirral**

Sent by email

Dear Mr Rebello

**Re: Regulation 28 – Prevention of Future Deaths Order**

Thank you for your e-mail on 10th May 2021 regarding the Regulation 28 – Prevention of Future Deaths Order issued to the Trust following the sad death of Eva Hayden.

The Trust have taken this extremely seriously and since receiving the Regulation 28 order we have reported this incident as a Serious Incident to the Strategic Executive Information System (StEIS) and we are undertaking a full Serious Incident investigation in line with our processes. The investigation is almost complete and should you so wish, we can provide a copy of this to you once finalised.

In relation to the issues raised with the Trust, we have also carried out a review of our ongoing processes and can provide the following information about the actions we have taken, and continue to take to ensure the robustness of our systems and processes moving forward in line with the points you raised:

a) *When investigating, diagnosing or treating a patient's presentation it seems reasonable that there should be good communication between clinician and patient with regard to the treatment plan. Understanding of the patient should be confirmed with regard to any precautions or risks arising from the condition. In this matter, Eva's parents had no knowledge of the pancytopenia or neutropenia under investigation and the risks of infection for Eva – such that this was not explained to the staff in the Emergency department at Alder Hey on 8th January 2020. Clinical practice should have prevented this eventuality.*

**Trust Response:**

1. At the time of this event there were paper-based systems in use, this has now changed and ward attender appointments are now scheduled on Medway (PAS) and clinically annotated at the time of the attendance. This ensures that patients are tracked and diarised electronically with outcomes recorded on the patient system.
2. The importance of ensuring clear communication with parents and/or children about conditions that are being investigated and the documentation of these conversations in the case note or electronic system has been re-emphasised to all clinical teams through staff meetings and regular communications. We provide copies of discharge letters and outpatient department

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clinic letters to parents. This will be followed up through a routine cycle of audits which will commence in July 2021 to ensure adherence to this directive and additionally to assess the quality of clinical information that is being recorded. We are working closely with Alder Hey team to ensure that families transferred from Alder Hey to Ormskirk for ongoing investigations have an understanding of the reasons and plans.

*b) When Eva missed the appointment at Ormskirk Hospital on the 25th November 2019 for her blood tests – there was no follow up by the hospital as there was an "assumption" that a follow-up orthopaedic appointment for cellulitis would investigate her neutropenia. The assumption was wrong and there was no clinical communication between the Trusts, which would have clarified that investigation of neutropenia had ceased without resolution. The onus for investigations cannot be on a four year old or her parents who were unaware of the potentially fatal implications.*

**Trust Response:**

3. The Trust immediately implemented safeguards to prevent a similar incident occurring when a child is not brought to a scheduled outpatient or ward attender appointment. ***All*** non-attendances are sent to the Consultant in charge of the care to clinically review and agree on what course of action needs to be taken. Examples of further actions could include, another appointment being offered or a discussion with another Trust if there are shared care arrangements. In all cases there will be documented evidence of the follow-up action that has taken place, e.g. letter to GP and/or parents.
4. We have completed a full audit exercise to look at the pathway and scenario that Eva was under as well as those patients that attend through a standard outpatient appointment. Whilst this identified that in the majority of cases, the existing DNA Policy and processes were followed; there were 5 occasions where a patient didn't attend an outpatient appointment and wasn't clinically reviewed. Each incidence has been reviewed clinically and there were no incidents of harm identified as a result.
5. We have reviewed our 'Did Not Attend (DNA)' Policy to reflect the requirements of the Regulation 28 report and ensure that any necessary safeguards from the work described above are contained within the Policy. The Policy has also been re-vamped to ensure it reflects best practice and principles that a child 'Was Not Brought' as opposed to DNA. The updated policy is due to be presented at the clinical business unit (CBU) governance meeting on 08/07/2021 and will be subject to the governance arrangements of the Trust. The Was Not Brought Policy is a corporate Policy and will apply to all children anywhere within the trust.
6. We are confident that the implementation of the actions described in points 3 and 5 above will ensure that there is a clear response each time a child is not brought to an appointment and we have introduced a routine audit to be undertaken every month to measure that our updated policy and processes are being adhered to. This will be monitored through speciality and CBU governance arrangements with any breaches against the policy being escalated through the Trust incident management processes.
7. In addition to our internal actions, we have met with the Chief Nurse and Medical Director at Alder Hey Children's NHS Foundation Trust (AHCH) for their input into the investigation and resultant actions recognising that Eva was also under the care of Alder Hey prior to her death and we want to ensure we have a full joined up understanding of the events that took place.
8. We are working with AHCH and the wider paediatric network to look at standardised communication and referral processes between Trust's, particularly where there are shared care arrangements.
9. We are also looking at all methods of entry into the Paediatric Department to ensure that we have clear, documented pathways and processes for how they are managed.

*c) What systems and training have been put in place to avoid a repetition of (a) & (b)?*

**Trust Response:**

10. The circumstances and details of this case have been widely shared. In addition, we are amending the local induction for staff in paediatrics to ensure that staff are provided with important information about the requirements of:
    a. Communication with families
    b. Communication with other organisations;
    c. What to do when children aren't brought to their appointments.
11. Amended policies and procedures will be issued for staff to read and sign to confirm they've understood the requirements.

I have attached a copy of the action plan being used to monitor progress against these actions in line with the above overview and trust this provides you with the necessary assurances that we have and are taking actions to address the concerns you raised. Should you require any further information or have any queries then please do not hesitate to contact me.

Yours sincerely

**Executive Medical Director**
**Responsible Officer & Caldicott Guardian**

Enclosure