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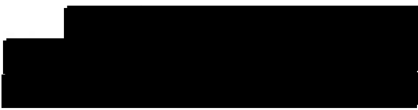


15 July 2021

Ms Alison Mutch OBE
HM Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch,

Trust Response to Prevention of Future Deaths Report issued following the Inquest touching upon the death of Mr Roger Ballard

I am writing in respect of your email dated 24th May 2021 by way of a Regulation 28 Report issued following the Inquest touching upon the death of Mr Roger Ballard, which concluded on 16th April 2021. I hope to be able to address the concerns raised in your report, and set out below my response in that respect.

Concern 1

The Inquest heard evidence in the way that the scan was reported and recorded was not clear and then contributed to the treating clinician not appreciating the scan findings.

When an investigation is undertaken such as a CT scan, it is expected that the treating clinicians should be logging onto the PACS system and reviewing the scan report instead of relying on what has been transcribed in the medical records. This is to avoid any misinterpretation or the omission of any detail, which may be vital when making a clinical decision about a patient's management plan and on-going treatment. This expectation is clearly documented in the Trust's Radiology Requesting and Reporting Policy, which all clinicians are required to be familiar with as part of their post at the Trust.

As determined during evidence at the Inquest of Mr Ballard, the treating clinician failed to review the CT scan and instead, relied on what had been documented in the medical notes alone, when making clinical decisions about Mr Ballard's care. This clinician wishes to forward his sincere apologies that this incident occurred. He has reflected on his own practice and discussed Mr Ballard's care and treatment with his operational line manager and also with a senior member of our clinical leadership team.

To reiterate the standards we expect of our clinicians, Mr Ballard's story is being shared across the Trust by way of a 7 Minute Briefing (enclosed for your information). The learning from this story has been put on the agenda for the Trust's Grand Round meeting, a regular forum attended by clinicians of all specialties and experience. It will be shared by Dr [redacted], Clinical Director for Urgent Care. In addition to this, Ms [redacted], Associate Medical Director, will share the learning from this case at the Clinical Advisory Group, which includes Clinical Directors and Medical Leads from all areas of the Trust and which is chaired by me as Medical Director. To ensure that all learning has been identified in relation to this issue, an investigation has also been commissioned as part of our serious incident framework and the findings of this will be presented to our Executive Scrutiny Panel which I and the Executive Director of Nursnig and Integrated Governance attend.

In addition, I wish to give you wider assurances around how imaging is reported and reviewed by clinicians at the Trust. The Trust has been developing a Results Governance Tracker, which has already been implemented in one major area of the Trust. It is anticipated that this roll-out will continue, although it did unfortunately experience some delays due to the pandemic. Once this Tracker is Trust-wide, it will ensure that all Pathology and Radiology results will have to be acknowledged as read on the PACS system within a specified timeframe. This will assist our clinicians in complying with the existing expectations on their practice and ensure safer care for patients.

Concern 2

The documentation regarding clinical decisions taken, including the decision not to follow the advice of the neurosurgeons was not documented in the notes. It was unclear if there was an expectation that where clinicians took a decision contrary to such advice how and in what detail the rationale should be recorded within the notes.

It is an expected standard that any decisions made relating to a patient's care and management plan are to be documented within the medical records. This includes discussions with tertiary centre colleagues, the advice they provide, and any decisions made to deviate from this advice and the reasons why. As I am sure you are aware, this requirement is within the GMC standards and guidance relating to documentation, and is absolutely expected from all medical staff. In addition, as part of junior doctor induction, clinicians are sign-posted to resources to assist them in managing their professional responsibilities and obligations regarding documentation in medical records.

The clinician involved in this matter has reflected on this point and learning has also been included in the 7 Minute Briefing, shared across the Trust. Further, a documentation standards audit has also been commenced and dependent on the

outcome and results of this audit, an action plan will be developed to address any issues identified.

I am pleased to advise you that our colleagues at Salford Royal Hospital (part of the Northern Care Alliance) have introduced an on-line referral process from 17th May 2021. This new system requires that all referrals to the Neurology Team at Salford are completed on a virtual platform. The advice provided will then be documented on this portal also. The written advice is available for the referring team, who are then expected to document the same and any decision and rationale to depart from this advice, if that is the decision they make regarding the patient's management. For your information, I enclose a leaflet produced by Salford Royal, which details how referrals are to be made under the new online system.

Finally, I wish to assure you that outcomes and learning from incidents, complaints and Safeguarding investigations are progressed through the Integrated Governance work streams, through the Divisional Governance Forums, and Clinical Leadership Forums. Where individual learning, or further measures are required, this will be undertaken within the existing Divisional mechanisms and HR processes. As the Trust has commenced an internal investigation into the concerns you have raised, this usual process will be followed.

I hope my response sufficiently addresses your concerns and assures you that they have been taken seriously. The doctors involved in Mr Ballard's care and treatment have extensively reflected on their actions, to ensure a similar occurrence is avoided. I sincerely apologise to the family of Mr Ballard for the obvious distress the care provided to him has caused them. I accept and acknowledge that the care fell below the standard expected and will be writing to them separately to explain the steps taken and to offer my condolences again.

Should you have any queries arising from the content of this letter or require further information or clarification, please do not hesitate to contact me.

Yours sincerely

Medical Director

7 MINUTE BRIEFING

LEARNING FROM INQUESTS

1: Background

On 16 April 2021, the Trust participated in the inquest into the death of RB, who sadly died at home on 30 September 2020, after care and treatment at TGH.

During the inquest, the Coroner raised concern with evidence that she heard from Trust witnesses and felt compelled to issue a Prevention of Future Deaths Report to the Trust.

2. Concerns

The Coroner's concerns were two-fold:

a) The way in which the CT scan was reported and then recorded was not clear and contributed to the treating clinician not appreciating the scan findings, and;

b) The documentation regarding clinical decisions taken, including the decision to not follow the advice of the neurosurgeons, was not documented in the notes. It was unclear if there was an expectation that where clinicians took a decision contrary to such advice, how and in what detail, the rationale should be recorded within the notes.

3. The incident

RB attended ED on 12/09/20 with a suspected head injury. He was admitted to AMU; neurological observations were undertaken, and a DNACPR was completed. RB was on anticoagulants and therefore a CT head was performed, and his anticoagulants were stopped. CT head confirmed subarachnoid haemorrhage and contusions to the left side of the brain. The findings were discussed with the Stroke Team and Mr Ballard was to be admitted with Beriplex. Salford Royal advised RB was for conservative management and that anticoagulants should be stopped. As his family wished for him to be at home, he was discharged, with an outpatient's CT scan in 2 weeks. RB was restarted on anticoagulants on discharge due to the risks associated with a PMH of AF.

RB attended ED again on 15/09/2020, with a suspected stroke. Anticoagulants were discontinued and ED discussed with Salford Royal who confirmed that RB was for no further intervention. On 17/09/2020 RB was palliated and discharged home. Sadly, he died at home on 30/09/20.

4. The Review

During the course of the inquest hearing it came to light that –

a) The decision to discharge RB with anticoagulants was made without the knowledge of the bleed on his brain. This was due to the discharging clinician not having reviewed the CT scan report (which was available in the notes) and instead, relying on what was written in the notes by another clinician, that RB had a contusion.

b) The discussion and reason behind the decision to discharge RB with anticoagulants (due to the high risk of stroke), and depart from Specialist advice, was not documented in the medical records.

5. Findings

a) The discharging clinician should have reviewed the CT scan report prior to discharge to ensure he was fully aware of the findings when making clinical decisions. Had the clinician been aware of the bleed, he would have stopped the anticoagulants and kept RB in for further observation.

b) The discharging clinician should have documented the reason behind the decision to depart from Specialist Advice from the Tiertiary centre.

6. Recommendations

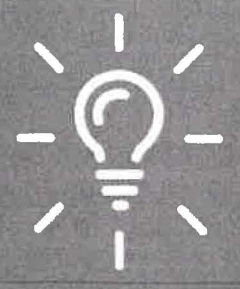
a) Personal learning and reflection for those involved in the care.

b) Sharing this story with Clinicians at all levels (Grand Round and CAG) to ensure they are reminded of the importance of reviewing imagining reports and of being familiar with Trust policies around head injury management and record keeping in patient notes.

7. Implementing change

a) Results Governance Tracker – The roll-out of this Tool is ongoing across the Trust and requires that all Pathology and Radiology results have to be acknowledged as read on the PACS system, within a specified timeframe. This will help ensure clinicians are reviewing imaging reports and not relying on medical records for full details of patients.

b) Taking Responsibility – Individual clinicians must take responsibility to ensure they are familiar with their duties regarding documentation.



The way of referring to the **Neurosurgery** On Call Team at Salford Royal is changing

Patient Pass

All referrals should now be made via the Patient Pass referral system.

To access the system, go to:
https://patientpass.srft.nhs.uk

Roll out due to commence 17th May 2021