Bradford Teaching Hospitals
NHS Foundation Trust

via Email
[redacted] [redacted]

[redacted]
Chief Executive Officer
Trust Headquarters
Chestnut House
Bradford Royal Infirmary
Duckworth Lane
Bradford
BD9 6RJ

[redacted]
www.bradfordhospitals.nhs.uk

12 July 2021

Dear Dr Howard,

I am writing with respect to the outcome of the inquest relating to the circumstances surrounding the death of Susan Roberts, which concluded on the 11 March 2021.

I am now in receipt of your 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) Regulation 2013) dated 9 June 2021 where you identify the following matters of concern:

1. There has been lack of timely and effective hand over between the different surgical specialties, with an absence of formal protocol.
2. That when asked for help at the time and during the investigation, there seems to have been a lack of engagement from the Plastic Surgeons. They failed to join the Orthopaedic Registrar in theatre at the time of the incident and then failed to attend the round table analysis as part of the SI investigation.

I would like to take this opportunity to confirm that we take opportunities for reflection and learning to help us improve the quality of care that we provide to our patients very seriously. I welcome the opportunity to respond to your concerns and outline the actions the Trust has taken in respect of these directions.

1. There has been lack of timely and effective hand over between the different surgical specialties, with an absence of formal protocol.

The Bradford Teaching Hospitals NHS Foundation Trust hosts an Electronic Patient Record (EPR). Routine referrals to specialities and individual consultants are made through this system. For time critical medical conditions it is the Trust's well established practice for a referral to be made directly to the specialty/consultant via telephone. As part of the recommendations following the investigation into this case a protocol for cases of Necrotising Fasciitis has been issued. The protocol clearly stipulates which speciality needs to be contacted and involved and at what point in the treatment dependant on the area of the body that is affected.

The protocol has been issued to consultants and is also available on the Bradford Teaching Hospitals NHS Foundation Trust's intranet pages.

2. That when asked for help at the time and during the investigation, there seems to have been a lack of engagement from the Plastic Surgeons. They failed to join the Orthopaedic Registrar in theatre at the time of the incident and then failed to attend the round table analysis as part of the SI investigation.

It is not acceptable for a team to fail to attend when requested to participate in a formal investigation of a patient safety incident. The Trust has an Incident Reporting and Investigation Policy which makes clear its commitment to patient safety and improving the quality of care that it provides, developing a just culture and encouraging staff to be willing to admit mistakes without fear of punitive measures. Staff are therefore actively encouraged and are supported to be open and honest about events and issues that have or could pose a risk to patient safety. It is the Trust's expectation that all staff participate in and support the investigation into a patient safety incident that they were either directly involved in or could provide insight into why such an event has occurred. The round table discussion approach to this investigation was a new methodology that was being tested with the intention to explore together as a multi-disciplinary team the events surrounding this case. The round table discussion for this incident took place early in the investigation and at that time it was not clear what the contribution the plastics team would provide. Subsequently statements were obtained from the relevant clinicians which were used to inform the investigation process, subsequent recommendations and actions. As the 'Round Table' approach to investigating incidents has matured as well as in response to the new national Patient Safety Incident Response Framework we are currently revising our Serious Incident Reporting and Investigating policy to make it explicit that all crucial staff attend the 'Round Table' discussion to establish the facts of the incident and identify key learning and areas for improvement not only for the local team but also organisational wide.

To address the point regarding attendance in theatre, we refer back to the earlier statement that it is standard practice that the plastics team will become involved once primary management of abscesses are complete and reconstruction is required. We intend to revise the referral protocol to make it explicit that the leading speciality is responsible for clearly documenting in the patient record the agreed plan with the secondary speciality at the point in the procedure they become involved and who this was agreed with. It must noted that the orthopaedic specialist registrar and the plastics specialist registrar in this case were in direct telephone consultation regarding the treatment of the surgical debridement and further treatment.

I trust that the information provided assures you that the Trust has taken appropriate actions to meet the requirements of your Report to Prevent Future Deaths.

Yours sincerely

Chief Executive Officer