NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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29th September 2020

Mr Christopher Morris
HM Area Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Morris

**Regulation 28: Report to prevent future deaths, following the Inquest touching upon the death of Mrs. Sylvia Scully**

I am writing in respect of your letter dated 11th August 2020, by way of a Regulation 28 Report issued following the Inquest touching upon the death of Mrs. Sylvia Scully, which concluded on 28th July 2020. I hope to be able to address the concerns raised in your report and set out below my response.

**Concern 1**

*The Trust's routine clinical governance process has not resulted in a formal Serious Untoward Incident Investigation or similar review in respect of SS's treatment and care. The Coroner feels this is a great matter of concern given the importance a robust and timely investigation has to patient safety.*

In order to address your concerns, I would first like to take the opportunity to explain the Trust's incident investigation process, which was effective at the time of Mrs Scully's attendance. I hope by explaining this and various other types of investigations the Trust undertake, it will provide you with reassurance that whilst a Serious Untoward Investigation was not undertaken in Mrs Scully's case, her treatment and care was reviewed by the Trust.

It is very important to the Trust that following any incident or complaint the immediate needs of the patient, member of staff or visitor must be attended to and remedial action taken to confirm a safe environment. In accordance with the Trust's Incident Investigation Policy, an incident report form is completed on the Trust Incident Reporting System at the earliest opportunity and the appropriate Senior Manager, along with other staff members are notified. It is then their responsibility to ensure that all immediate action required has been undertaken and is appropriately documented.

A preliminary investigation must be completed for incidents or complaints where a moderate degree of harm or above has resulted and any events categorised as having an impact of severe harm/death must be verified by the Line Manager or the person in charge immediately following the incident. The Line Manager will then subsequently reassess and re-grade the harm level where the incident has been found to have been given an impact of severe harm/death inappropriately and inform the Integrated Governance Team.

The Trust policy categorises three levels of investigation, all of these are linked to the levels of harm to the patient or affected person. Please be assured that this is in accordance with the levels of harm adopted by the National Reporting and Learning System (NRLS), NHS England and former National Patient Safety Agency and are as follows;

1. ***No harm***

Patients are not normally contacted or involved in such investigations. Where these types of incidents involve complaints, 'Being Open' principles are adopted and the outcome of any investigation and meetings shared with the affected person or their next of kin.

2. ***Low/Minor***

Unless there are specific indications or the patient specifically requests it, communication, investigation, analysis and the implementation of changes will occur at local service delivery level. In terms of sharing the outcome with the patient or their family, acknowledgment, apology and explanation will be communicated in the form of an open discussion between the staff providing the patient's care and the patient and/or their carers. This is documented in the form of either patient records, letters to patients or notes of meetings with patients or the families.

3. ***Moderate, Severe, Death and Catastrophic***

In accordance with Trust policy, all harm that is classified as moderate or severe or where 'prolonged psychological harm' has arisen gives rise to our Duty of Candour process, instigating direct contact with the patient or person lawfully acting on their behalf. This duty will also apply in cases of death, if this relates to the incident of harm as opposed to the natural course of the patient's illness or underlying condition.

Quite understandably, a higher level of response is required in these circumstances and so the Trust's Director of Nursing & Integrated Governance or Head of Assurance & Governance are consulted and are available to provide support and advice during the process. Duty of Candour requires that as soon as reasonably practicable after becoming aware that a notifiable safety

incident has occurred, the Trust must notify the patient/relevant person. The Trust aim to complete Duty of Candour within 10 days of the incident being raised, in accordance with NHS Standards Contract.

The Trust have adopted a "SWARM" approach where a serious untoward incident (SUI) is suspected. This SWARM meeting is to take place as soon as possible after the incident has occurred and is based on the concept of "swarm intelligence" where the collective intelligence is greater than that of individuals. It is required to gather and analyse the facts pertaining to the incident and to identify suitable risk control measures. The SWARM response team will report on the key findings, immediate actions taken and outcome, following which a decision is made regarding further investigation.

It is vitally important that the Trust learn from incidents and feedback and as such, the Trust encourage all staff to report patient safety incidents during a patient's journey and also retrospectively as a result of complaints, PALS concerns, inquest preparations, clinical audit, the medical examiners reviews. The levels of investigation into such incidents focuses on ensuring a thorough and robust investigation proportionate to the outcome, and ensure investigations seek to understand what happened, why it happened and recommend what systems or processes should be put in place to prevent future occurrence.

In addition to reviewing all incidents reported daily, the Integrated Governance Team also hold a weekly meeting chaired by the Head of Assurance & Governance and attended by Head of Complaints, PALS & Candour, Head of Patient Safety, Inquest & Claims Lead and Mortality Lead. Complex complaints, Inquests and incidents are discussed in detail and decisions are reached as to what is considered to be the best course of action. It is felt that this weekly meeting provides an extra level of scrutiny of issues that at times do not coincide with normal processes.

Outcomes and learning from incidents, complaints and Safeguarding investigations are progressed through the Integrated Governance work streams, through the Divisional Governance Forums, Senior Nursing and Midwifery Leaders Forum and Senior and Junior Doctors Forums. Where individual learning or further measures are required this will be undertaken within the existing Divisional mechanisms and HR processes.

As you may be aware in the case of Mrs Scully, an incident was raised by the Consultant Surgeon on 10th February 2020 following the misreporting of her CT scan. In accordance with the Trust processes detailed above, the incident and death was reviewed by the Integrated Governance Team, together with Surgical Lead and Consultant General and Colorectal Surgeon. The outcome of this review determined that despite the error in radiology reporting, this did not impact upon Mrs Scully's management plan and that both reported scans indicated a serious intra-abdominal condition warranting surgical intervention. It was further confirmed that Mrs Scully was seriously unwell with a considerable PPOSSUM Score and that assessment by the Anaesthetist and Consultant Anaesthetist confirmed that Mrs Scully was not a candidate for high risk surgical intervention.



Based on this information, a decision was made by the Team to grade the incident as 'No Harm'. In view of concerns raised and as part of the coronial process, it was acknowledged

that there was an existing Duty of Candour relating to the misreporting of the CT scan and highlighting areas of learning, which were subsequently outlined in the coronial statement of the Consultant Radiologist and accompanied by an action plan outlining areas of learning for the Trust. It is acknowledged that the review into the misreported radiology incident was an opportunity to further review Mrs Scully's full episode of care within the ED, including the length of time to request investigations and reach decisions regarding her on-going care.

It is appreciated that this level of scrutiny is not always apparent and evident for the purpose of the Inquest therefore, the Trust's Integrated Governance Team have considered how they can evidence different responses to patient safety incidents,, including Multi-Disciplinary Team reviews, complaints investigations and expert opinions, which occur outside of a formal SUI process. A new 'Case Review and Lessons Learned' document has been produced which will be provided as part of the coronial disclosure process. Senior Clinicians with the expertise in the area of concern will undertake such case reviews. The findings and lessons learned document will be presented in a 'Case Review and Lessons Learned' report which the Trust intend on disclosing as part of the coronial process for the benefit of the family and Court if a serious incident investigation is not required.

**Concern 2:**

*A Rapid Assessment and Treatment Model was not in use in ED at the time of SS's attendance, which was relevant to walk in patients. Such a paradigm would have resulted in SS being seen earlier by a Senior Doctor who had the experience and authority to initiate relevant investigations (including CT scan) and treatment, in advance of review by the surgical team.*

It appears from reviewing the notes made by the solicitor representing the Trust at the Inquest, that you may not have been adequately informed regarding the Triage process for patients attending by ambulance and those that "walk in". Please be reassured that all patients attending the Emergency Department (ED) are treated in the same way and the outcome of their initial assessment will determine their Triage category, which will in turn identify how quickly they need to be seen. I am very sorry for any confusion caused at the Inquest and would like to provide further clarity and assurances around the Trust's triage and assessment processes.

As you may be aware, the Trust use the Manchester Triage Tool, which is adopted nationwide and is guidance given to suggest timeframes patients should be medically assessed based upon their triage outcome/category. There are occasions where these timeframes cannot be met, which is why patients in ED are regularly reviewed by the nursing staff and routine observations National Early Warning Scores (NEWS) are completed. If a NEWS score is concerning the nursing staff should escalate this to a doctor for a sooner assessment. Patients attending ED are seen in priority order.

We acknowledge that NHS England have suggested that Emergency Departments consider implementing Rapid Assessment and Treatment (RAT) models, with the aim to provide early senior assessment of undifferentiated 'majors' patients and achieve both their 'time to assessment' and 'time to treatment' indicators. The Trust have considered the use of these

models and their applications and have continuously reviewed them along with staffing requirements in light of the COVID-19 pandemic. The Trust have adopted new ways of working to ensure patients who are categorised as a 1 or 2 are seen in a timely manner. Between Monday to Friday, 08.00 hours to 22.00 hours and on weekends between 10.00 hours to 18.00 hours, there is a "Lead Consultant" allocated to ensure these urgent patients are seen within 30 minutes following Triage. This is to ensure these patients are seen by the appropriate team and appropriate investigations are requested quickly. When a Triage Nurse has undertaken her initial assessment, it is then their responsibility to immediately highlight them to the Team Leader.

These Consultants are expected to assess the triage records to identify any patients where specialist or Consultant input is required. There are specialist "hubs" on site which were introduced in March 2020, including surgical hubs where a patient could be directly referred to for input. As you will be aware, these specialist hubs would not have been in place at the time of Mrs Scully's attendance. These were introduced to further reduce pressures and ensure safety in the Emergency Department and create a more efficient service, the Trust have developed an escalation process in which patients who present to the Emergency Department with certain presentations can be transferred to specialist hubs. These hubs include Surgical, Ear Nose & Throat (ENT), Orthopaedics and Gynaecology. These hubs are run by Consultants of the relevant discipline.

Furthermore we are in the process of introducing two Consultants to work within the Emergency Department at the weekend, and have recruited to these posts. Currently we have 1 on- call Consultant who are rostered to work in the department between the hours of 10.00 and 18.00, 8 middle grade doctors and 8 junior doctors. It is hoped that this extra resource of an additional Consultant will be implemented in time for the winter pressures we are anticipating to face this year, which as I am sure you can appreciate, will be much more profound this year considering the unprecedented times we face.

The Trust have also created a new flowchart and blood tests catalogue on Lorenzo (our patient information electronic information system) which advises our ED nursing staff of immediate blood tests required for the majority of the presenting complaints which include abdominal pain and chest pain. This will allow blood results to be processing and readily available when the medical assessment is being undertaken, allowing for swifter decisions to be made. This new flowchart has been shared with the Royal College of Emergency Medicine (RCEM) who have advised they would like to host this on the RCEM website for other Emergency Departments to utilise.

The Trust are also in the process of developing an Abdominal Pain Pathway, which is hoping to achieve that within 2 hours of arrival, patients presenting to the Emergency Department with abdominal pain will have had a CT scan undertaken if their clinical presentation indicates that this is required. This is in the final stages of agreement as it involves the Emergency Department Teams, the Surgical Team and Radiology and is expected to be in place by the end of October 2020. It is believed that this pathway will reduce the waiting times patients experience who require CT scans due to abdominal pain and expedite the surgical review, resulting in a timelier plan of care being proposed.

I hope my response sufficiently explains the existing processes here at the Trust and implementation of new measures not only addresses your concerns but minimises the likelihood of similar occurrences taking place and will enable the Trust to provide safe and effective care to all our patients. I sincerely apologise to the family of Mrs Scully for the obvious distress the care provided to Mrs Scully has caused. 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.

I hope to have addressed your concerns, however 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

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**Chief Executive Officer**