2 8 MAY 2014

St. George's Healthcare NHS Trust
Blackshaw Road London SW17 0QT

Mr. Martin Fleming
Assistant Coroner for Surrey
Station Approach
Woking
Surrey GU22 7AP

16 May 2014

Dear Mr. Fleming

Re: Rainer Wickens Inquest 28 April – 2 May 2014

I write further to the above inquest which concluded on 2 May 2014. I have been informed of your legitimate concerns about the delay in declaring and undertaking a Serious Incident (SI) investigation in this case, and also the doubts you expressed about the potential for the completion dates for the SI panel's recommended actions slipping. I am therefore writing to provide some explanation which I hope will address your concerns.

The trust has already apologised sincerely to [redacted] for the sub-optimal care provided to Mr. Wickens in Sept 2012 and also for the delay in undertaking the SI investigation. I would also like to take this opportunity to apologise to you for the delay in declaring and undertaking this internal investigation. I realise that this delay hindered your own investigation into Mr. Wickens' death due to the time lapse between the incident and the inquest hearing, which meant that witnesses were not able to recollect events clearly.

Incident reporting

The trust has a robust process for incident reporting and takes this element of patient safety extremely seriously. All staff, including nursing, medical, allied health and administrative, are aware of the trust's electronic adverse incident reporting system. Experienced staff in the Risk Department review all reported adverse incidents rated severe or extreme, as well as those flagged to the team as potential Serious Incidents. Those which meet the criteria for consideration as a Serious Incident (in line with national guidance) are then discussed at the Serious Incident Declaration Meeting (SIDM) every Monday.

The SIDM is chaired by me, and attended by key senior staff including the Chief Nurse, Director of Corporate Affairs, Associate Medical Director, Head of Patient Safety and Corporate Risk and Assurance Manager. Potential Serious Incidents (SIs) are presented to the SIDM for consideration and declared as SIs as required. SIs are reported using STEIS (Strategic Executive Information System), following which Wandsworth CCG and NHS England are notified.

Regrettably, in Mr. Wickens' case, the delay in undertaking the CTPA was not reported on the adverse incident reporting system as it clearly should have been. Although not entirely foolproof, there is usually also another mechanism for picking up on unreported adverse incidents, in that they could potentially have been recognised by either the Complaints team, had a family got in touch with the hospital with any concerns, or by the Legal team, had any Coroner's office requested statements from clinicians via the Legal office. Unfortunately, the Consultant who initially reported Mr.Wickens' death to the Inner West London Coroner's office provided a report direct, and so another opportunity to recognise the delay in the CTPA as an adverse incident was missed, until the Legal team started collating statements for your enquiry from mid-January 2014 onwards when it became apparent to the legal team that there had been a delay in undertaking the CTPA which should have been reported as an adverse incident. The matter was then raised at SIDM at the next available opportunity, the incident declared as an SI and a detailed investigation was immediately commenced and expedited in order to ensure that both the family and you were provided with the final report before your own enquiry commenced.

The failure to report this incident in a timely manner is most disappointing considering the systems and processes the trust has in place to facilitate and actively encourage reporting of all adverse incidents. The trust has one of the highest incident reporting rates nationally as evidenced by the National Reporting and Learning System (NRLS) report and benchmarking which places the Trust in the top quartile for reporting when compared with other similar organisations, which is indicative of a positive safety culture.

Actions taken

I would like to take this opportunity reassure you of the actions taken at the trust to remind staff again of the need to report all adverse incidents in a timely manner, and the consequences on patient safety of failing to do so.

- I have personally discussed the missed opportunities for the early reporting of this incident with each of the clinicians involved in Mr. Wickens' care who potentially could have logged an incident report.

- Ongoing training is being provided to all appropriate staff groups to ensure potential serious incidents are recognised and reported to the Risk team immediately.

- New doctors on rotation are reminded of the trust's patient safety agenda and adverse incident reporting system

- There is a continuous organisation-wide effort to promote an incident reporting culture as evidenced by a number of initiatives including the establishment of a regular staff safety forum (led by myself, the Chief Nurse and Head of Patient Safety) where serious incidents are discussed to ensure we have trust-wide learning and serve as a useful way of refreshing key safety messages.

- Our participation in an annual patient safety week which, though a series of themed daily events, raises awareness and helps to promote a culture where patient safety is seen as a key trust priority.

- We are currently carrying out a patient safety week initiative enabling staff feedback on their safety concerns. Themes from this will enable work on the issues identified to demonstrate the trust's commitment to recognising and acting upon safety issues
- We also have a quality improvement strategy (signed off by the Trust Board) which describes, using the three domains of quality (safety, experience and outcomes) how to improve the standards of care and safety for our patients

SI Action Plan

As you are aware, the SI investigation highlighted a number of failures and missed opportunities in the care provided to Mr Wickens. The SI investigation and the learning outcomes have since been shared with the immediate teams who had looked after Mr. Wickens and will continue to be disseminated through various patient safety initiatives as described above. You will also be pleased to hear that we now investigate and undertake root cause analysis and disseminate the learning on all cases of hospital acquired thrombosis.

The SI panel made a number of recommendations in the final report. All actions have been assigned to senior staff to lead on implementation. Some of these actions have been completed with the rest due for completion by 31 July 2014.

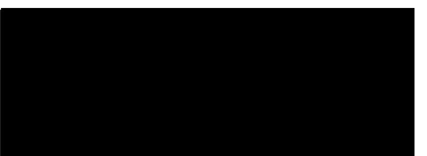
All actions are presented to the Patient Safety Committee and a regular audit of the actions contained within any SI action plan is also presented to the committee on a bi-annual basis. The Patient Safety Committee meets monthly and is a Trust Board sub-committee with the remit of ensuring that actions are implemented and learning is shared.

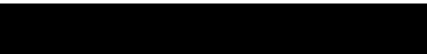
I hope I have been able to convey, by way of this letter, the trust's absolute commitment to ensuring that patient safety remains central to everything we do, and in that regard we are working continuously to promote a culture of early reporting of incidents and to ensure wider learning opportunities are disseminated to all staff.

I would also like to provide assurance relating to your concern that the timelines for implementation of the actions identified in Mr. Wickens' case could slip. The trust does have routine and stringent processes in place to ensure that all actions from all SIs are monitored and audited, as described above. I will be very happy to provide you with an update of the actions in August 2014.

If you require further information or assurance about this matter, please do not hesitate to contact me.

Yours sincerely





Medical Director