1/10/14

From Rt Hon Norman Lamb MP
Minister of State for Care and Support

Department of Health

Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Mrs M Voisin
HM Senior Coroner for Avon
The Coroner's Court
The Courthouse
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29 SEP 2014

Dear Mrs Voisin,

Thank you for your letter to Jeremy Hunt about the death of Mr Werrett. I am saddened to hear of Mr Werrett's death, and offer my sincere condolences to his family.

Your report details the events prior to Mr Werrett's death which included x-rays which were inverted and mislabelled, resulting in the drain being inserted on the wrong side of Mr Werrett's body. This resulted in an additional drain, which was found to have been a contributory factor in his death.

You listed a number of concerns about the insertion of these chest drains and the mistakes made in Mr Werret's care. These have, I understand, been addressed by North Bristol NHS Trust.

However, I have noted your suggestion that the safety check list and guideline that the Trust has implemented since Mr Werrett's death might usefully be shared with other organisations in the NHS to prevent future deaths.

The risks of inserting a chest drain on the wrong side are already to known to the NHS through patient safety incident reports received through the National Reporting and Learning System (NRLS).

The NRLS is a database of patient safety incident reports submitted voluntarily by organisations across the NHS. Trusts regularly upload incident reports from their local systems to the NRLS specifically for purposes of learning. Data is interrogated by national patient safety experts to spot trends, specific incidents of concern, or emerging risks to patient safety.

The WHO Surgical Safety Checklist was designed as a tool to improve the safety of surgery by reducing deaths and complications. The checklist specifically addresses

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issues relating to wrong site surgery which includes the insertion of drains. An NPSA Alert issued in 2009 recommended that the checklist should be adapted for local use. The alert can be found at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59860.

NHS England (NHSE) has recently established a Reference Group to take forward the recommendation made by the Surgical Never Events Taskforce in February 2014. This Taskforce was commissioned to examine and clarify the reasons for the persistence of these patient safety incidents, and to produce a report making recommendations on how they can be eradicated http://www.england.nhs.uk/ourwork/patientsafety/never-events/surgical/.

One of the key recommendations in this report is to develop National Standards for Operating Department Practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures. The scope of the standards will cover all surgical procedures and not just those being undertaken in the operating theatre environment. Current timescale for the development of the standards is early 2015.

Once the standards have been developed the next phase of this work will be to address how the standards should be implemented and this will include requirements for educators, commissioners and regulators.

If North Bristol Healthcare NHS Trust would share the checklist it has developed with NHS England there may be opportunity to include it as a resource for other Trusts to use or adapt when the standards are implemented.

I hope that this information is helpful and I thank you for bringing the circumstances of Mr Werrett's death to our attention.

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NORMAN LAMB