University Hospitals of Leicester NHS
NHS Trust

[redacted]
Chief Executive

[redacted]

[redacted]

Mrs Catherine Mason,
Her Majesty's Coroner,
Leicester South,
Leicester Town Hall Square,
Leicester.
LE1 9BG

5th November 2014

Dear Mrs Mason

Re: Regulation 28 Report to Prevent Future Deaths

I acknowledge receipt of the Regulation 28 – PFD report from your office, dated 18th September 2014,in which you request to be advised of any actions that have been taken to improve and oversee the preparation and conclusion of RCA (Root Cause Analysis) Investigation reports; and suggest that consideration be given to introducing a system to re-open any such reports found to be inadequate or erroneous.

First, I would like to apologise that, on this occasion, the root cause analysis investigation report was not helpful. I accept that information was presented by clinicians at inquest that was not covered in the RCA report and this must have been frustrating for your assistant deputy who heard this inquest. However, the purpose of these internal patient safety investigations is to learn lessons and implement solutions which prevent recurrence. By their very nature, they often contain differing clinical opinion and judgements. We use the RCA reports as a tool for listening, learning and improving, as well as providing a documented account of the facts for the patient/family.

The Trust continually works to improve the quality of the investigations of the RCA reports and we have recently introduced three further measures to assist with this.

1. From April 2014, the Trust has established a process whereby each RCA investigation has a named 'Chair'. This individual is either the Medical Director or Chief Nurse or one of their nominated deputies (i.e. Deputy

Medical Director, Director of Safety and Risk, Deputy Chief Nurse). The RCA Chair will review the terms of reference and scope of the investigation; ensure the appropriate investigation team has been established and ensure that an adequate ('SMART') action plan is produced. In addition to the Clinical Management Group (CMG) Director, the RCA Chair will also sign off the report.

2. The Trust has recently purchased external expert RCA training:-

   - Basic RCA training for investigation leads.
   - RCA Masterclass training for senior patient safety investigators.
   - RCA Oversight training for RCA Chairs.

3. The Trust has established a new 'Adverse Events Committee', reporting to the Executive Quality Board, to review all serious untoward events (SUIs).

   - This new Committee will ensure sufficient senior scrutiny is given to the events that cause avoidable death and harm. A collective understanding of the root causes, the themes and the actions required to reduce similar failings is required to ensure appropriate safety workstreams are in place.

   - The Adverse Events Committee will provide a systematic review of every action plan, tracking all actions to full implementation.

With respect to re-opening investigation reports, the Trust does consider any feedback received from Commissioners and may make amendments to such reports if there is compelling evidence to do so.

I hope that this provides you with assurance that we strive to provide comprehensive and accurate reports. Although these reports are not written for any legal purposes, either claims or inquests, we are very willing to share them externally should they be useful to you.

We always welcome feedback from your office and whilst I fully understand your concern regarding the RCA Investigation in this case, I was a little surprised that it has resulted in a Regulation 28 Report. However, we note your concerns and strive to continue to improve our investigation and reporting processes as detailed above.

Yours sincerely,

[redacted]

[redacted]
Chief Executive

Cc: [redacted], Director of Corporate and Legal Affairs
[redacted], Chief Nurse
[redacted], Director of Safety and Risk
[redacted], Assistant Director (Head of Legal Services)