University Hospitals of North Midlands NHS
NHS Trust

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STRICTLY PRIVATE & CONFIDENTIAL
Mr I S Smith
H M Coroner
Coroner's Chambers
547 Hartshill Road
Stoke on Trent
Staffs
ST4 6HF

Dear Mr Smith,

Arthur FRY

Further to my letter dated 10 July 2015, I am pleased to provide a response to your report under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Mr Arthur Fry.

Background

Following symptoms which began in late 2013, Mr Fry was diagnosed in February 2014 with a brain tumour subsequently typed as glioblastoma multiforme WHO grade 4. On 14 April 2014 at the University Hospital of North Staffordshire, Stoke on Trent, he underwent debulking of the tumour by means of a temporal craniotomy. The procedure was successful initially and he was making good recovery until the late evening of the 15 April 2014 when he developed a markedly elevated high blood pressure and significant neurological deficit. An MRI scan planned for the afternoon of 15 April 2014 had not been carried out because of a breakdown in communication. A CT scan performed at about midnight revealed a subdural haematoma, midline shift and features suggestive of infarction of the thalamus. The deceased was taken back to theatre and the haematoma was evacuated. No specific bleeding point could be identified rather a generalised bleed from the operative site. Following the procedure his intracranial pressure continued to rise and a CT scan at 6.55am on 16 April 2014 showed extensive infarction of the left hemisphere and of the brainstem. Mr Fry's condition did not improve and he died at 10am on 17 April 2014, and that earlier diagnosis would not have made any significant outcome.

The Conclusion of the inquest was that Mr Fry died as a result of a recognised complication of surgery.

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Concerns

During the course of the inquest you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows:

1. You heard evidence that an MRI scan had been scheduled for 15 April 2014 because this was the routine practice for all tumour patients. Mr Fry was taken to the MRI scanning but was declined by the radiographer because of an issue over safety and a further consent form was required by two doctors.

   The refusal of the radiographer to undertake the scan for safety reasons was not known to the consultant or his team and there was a breakdown in communication. The failure to carry out the MRI scan may have impacted upon the deceased's care. Tighter controls concerning the requisitioning of procedures (in this case MRI and CT scans) needs to be designed to avoid confusion and potential failures to carry out the procedures. You are aware that recommendations have been put forward but would like to be sure that they are being implemented.

Action Taken

At the inquest, Matron Meehan presented evidence to the Court relating to internal investigations which had been undertaken by the Trust following the death of Mr Fry. The depth and scrutiny of the report was commended by the family and they were pleased to see that measures had been considered in order to prevent such matters reoccurring with other patients attending the University Hospitals of North Midlands (formerly the University Hospital of North Staffordshire).

Within her report and from evidence given by [redacted] Consultant Radiologist, it was heard that radiologists have taken steps to improve communication between the imaging department and ward areas. It was explained that all radiographers now document the name of the accompanying nurse and explicit instruction for the ward clinical team are entered into the electronic CRIS system. At the time of the inquest, [redacted] also made suggestions for improvement and we are able to provide the following update in relation to the progress that has been made.

1. Consider whether all post-operative neurological patients should come to MRI scan with a two-doctor consent as they all have the potential to deteriorate / become confused.

   Following the inquest representatives from the Imaging Department attended the Neurosurgical Governance Meeting to discuss whether it was appropriate to develop an abbreviated version of the safety checklist and to discuss whether this approach would be beneficial for all post-operative tumour patients. Following discussion, the solution proposed is incorporating the following phrase into the safety questionnaire / Order Comms process: "This patient's MRI compatibility has not changed since the last MRI scan". This is in the process of being signed off through the Divisional Governance process.

2. Imaging Assistants visit the patient on the ward pre-scan to complete safety questionnaire.

   The Department of Imaging have applied for transformation funding to initiate this service. If successful, it will negate the need for the abbreviated version of the safety checklist as Imaging Assistants will visit the patient on the ward pre-scan to assess the patient.

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3. Escort nurses have a written handover on return to the ward from MRI. This measure was in the process of being implemented at the time of the inquest and Trust policy C24 (Policy for the Handover, Transfer & Escort Arrangements of Adult Patients between Wards and Departments) has a form for use on page 23.

As such, I sincerely hope that this report provides you with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising from the inquest touching upon the death of Arthur Fry seriously. I believe that there is evidence to confirm that the Trust drew from the concerns raised by the family and that practice has been changed in light of their concerns.

The Trust strives to provide a high standard of care to all patients, and I am grateful to you for raising these matters on this occasion. Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

MARK HACKETT
CHIEF EXECUTIVE

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