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CR/AF/SCC

1 December 2015

Mrs Louise Hunt
HM Senior Coroner for Birmingham and Solihull
50 Newton Street
Birmingham

Dear Mrs Hunt,

Inquest into the death of Mr Adrian Mark Smith – Report to Prevent Future Deaths

I write in response to the Regulation 28 Report made by you following your investigation and inquest into the death of Mr Adrian Mark Smith on 14 October 2015 and your letter to Dr Andrew Catto (Executive Medical Director) dated 16 October 2015.

I am responding on behalf of Dr Catto and in my capacity as the Trust Deputy Medical Director.

The Heart of England NHS Foundation Trust (the "Trust") has carefully considered the important matters raised by you at the inquest and I set out the Trust's response below:

1. Clear instruction was given by the Queen Elizabeth Hospital to undertake an MRI scan to confirm the possible diagnosis. This instruction was not followed by the staff at Good Hope Hospital. Systems need to be put in place to ensure that specialist advice is followed.

In responding to your Regulation 28 Report, we have sought the views of the senior responsible clinician for radiology, Dr John Reynolds (Clinical Director).

When reflecting on this case, [redacted] has discussed with me that it is a rare occurrence that a specialist requested radiological investigation is declined by a consultant radiologist. [redacted] suggests it is a maximum of 1% of specialist requested investigations that are questioned and the decision to decline a requested investigation is always made by a consultant radiologist in discussion with members of the clinical team responsible for the patient. It should be acknowledged that the radiologist involvement is not simply technical (to do as told) but to provide an opinion and action a clinical request based upon need.

The initial contact with the external neurosurgical team is normally made by a member of the clinical team caring for the patient speaking to a neurosurgical registrar and inevitably the experience of the registrar can be variable. [redacted] has advised that there have been no reported incidents where a patient has suffered an adverse outcome following a radiological investigation being declined. This does not however minimise the seriousness of the concerns raised regarding the potential risk to patients in our care.

When considering any radiological investigation request I have been informed that the following is routinely considered: First, whether the requested investigation is likely to identify new clinical information, and secondly whether the investigation is likely to lead to clinical intervention. These points are considered alongside the risks for each individual patient, and the demands on the service.

In order that the risk of future events can be reduced the following steps have been taken by the Trust:

1. In the circumstances where a consultant radiologist does not believe that a requested radiological investigation is likely to identify new clinical information or lead to clinical intervention, before the request is declined they will now discuss the case with a HEFT peer consultant radiologist to seek a second opinion and ensure that their assessment is both reasonable and logical. The consultant in charge of the patient's care will also be involved in the discussion.

2. In addition to strengthening the decision making process, if after a peer discussion, both consultant radiologists are of the professional opinion that the investigation should not be undertaken, or an alternative investigation should be undertaken, how this is communicated to the neurosurgical team will change. Currently the process would be that the treating clinical team liaise with the neurosurgical team regarding patient management, and it is the treating clinical team that currently communicate the decision to decline any requested investigation. The process, in future, will be that if the decision is to query the requested investigation then the consultant radiologist will speak directly with the senior neurosurgeon to discuss the case and their clinical decision. This will facilitate open discussion between senior clinicians to ensure the correct clinical decision is reached for each individual patient.

In order to facilitate this more collaborative working approach, [redacted] has agreed to liaise with the Clinical Lead for Neurosurgery at Queen Elizabeth Hospital, [redacted] and the Divisional Director for Division [redacted] to ensure that the neurosurgical team are aware of and approve our proposed changes.

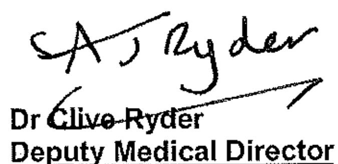
To ensure these actions are consistently applied across the radiology directorate [redacted] has agreed to develop a standard operating procedure (SOP) that clearly and concisely articulates the strengthened process.

Finally, in sad situations such as this, it is important that the family of Mr Smith are made aware of the steps that we are taking to reduce the risk of future events. I will arrange to meet with the family directly.

If I can be of any further assistance, please do not hesitate to contact me.

Best wishes.

Yours sincerely,



Dr ~~Clive Ryder~~
Deputy Medical Director

Encs

cc
Dr Andrew Catto, Executive Medical Director
[redacted] Chief Nurse

[redacted], Deputy Director of Governance
Dr David Rosser, Deputy Chief Executive
[redacted], Director Division D QEHB