Tameside Hospital NHS
NHS Foundation Trust

Quality & Governance Unit
Tameside General Hospital
Fountain Street
Ashton-Under-Lyne
Tameside
OL6 9RW

Telephone: 0161 922 4466
Fax: 0161 922 6190

Date: 23 March 2016

Your Ref: JSP/ER/01978-2015
Our Ref AD/KJ/01978-2

Mr John Pollard
Senior Coroner for Manchester South
The Coroner's Court
1 Mount Tabor
Stockport SK1 3AG

Dear Mr Pollard,

Re: Regulation 28: Report to Prevent Future Deaths following Inquest into the death of Derek Edward Hare (Deceased)

I write further to your letter dated 16th March 2016 in relation to the Trust's response to your Regulation 28 Report issued following the Inquest, touching upon the death of Derek Edward Hare, on 13th January 2016. I am very sorry that you had cause to contact me again and that you found the response given to point 1 of your Regulation 28 Report unsatisfactory.

I hope to be able to address your concerns as set out in section 5 of your report, to your satisfaction in this letter. With reference to why the response to your Regulation 28 Report typed on the 8th February took a month between being typed and being sent to your office, I am very sorry for the confusion this caused and would like to assure you that this was a clerical error, and the letter should have been dated 28th February not the 8th February.

In response to point 1, you stated:

1. ***It would appear that throughout his various admissions to the hospital, two completely separate sets of "notes" were open and being used. Thus when the doctor tried to refer to the notes in court, he could not do so and had to seek a short adjournment to find the relevant entry. If this were the case when the patient was in the hospital, it is hardly surprising that errors were made and staff members were not clear as to what would comprise the optimum care for this patient. It was not a question of large case notes which run into two volumes, this was a situation where both sets of notes were apparently open at the same time and doctors were therefore putting new notes into one or the other but not properly into one single document.***

In respect of your concerns regarding the case notes I recognise that staff entries into the records should be in one set of records which should be the current ones in use during the patient's admission. This is the Trust's standard and expectation and has been reiterated to the Consultant Clinical Leads, Lead Clinicians and Senior Nurses in the Clinical Divisions for dissemination to all staff and for discussion at their Clinical Governance and team meetings. As you have highlighted where it is necessary to provide two sets of notes for reference to the previous history and continuity of care there is a risk that medical staff may enter their notes in the older set of notes. This reiteration and reinforcement of the record keeping policy will minimise this.

I have sought further clarity as you suggested on the problems encountered at Mr Hare's Inquest in this regard and have liaised with Mr Siddiqui. As previously stated two large sets of case notes pertaining to the patient were made available for Inquest. The Consultant Mr Siddiqui maintains that he was asked to clarify a date in response to a question raised by Mr Hare's relative. Mr Siddqui informs me that he found it necessary to look at the notes which were in a different volume of the case notes and as such had to manage both volumes at the Inquest. I acknowledge that this was not ideal and further enquiries have informed me that it appears that one set of case notes has records filed up to the 27/05/15. This volume held some of the notes Mr Siddiqui had to access (these related to the surgical care) in response to your questions. The other volume has records up to the patient's death on the 12/08/15. This contained medicine specialty notes and notes where the surgeons had been asked to review Mr Hare) which were also pertinent to the questions asked.

I am very sorry that this resulted in you having to adjourn the Inquest to give time for Mr Siddiqui to find the entry and for any inconvenience this caused you in respect of your HM Coronial Hearing. I also recognise that this gave rise to your concerns in relation to the Trust's ability to provide high quality care for the patient. I hope you will find my actions in relation to the concerns you have raised satisfactory.

I would like to assure you that I have taken your concerns seriously and I hope that I have addressed your concerns and reassured you of all that the Trust has already undertaken and is currently undertaking, in order to prevent the recurrence of a similar set of circumstances in the future.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me.

Yours sincerely

Karen James
Chief Executive