



11 July 2016

Dr Karen Henderson
HM Assistant Coroner for Coroner Area of Surrey
HM Coroner's Court
Station Approach
Woking
Surrey GU22 7AP

Dear Dr Henderson

Regulation 28 Report – Mr John Crittall

I am writing in response to your Regulation 28 Report of 16th May 2016 following the Inquest of Mr John Crittall addressed to BMI Healthcare's Chief Executive Officer, which has been passed to me to respond.

You have asked for a response to the matters of concern raised within the report and to detail the proposed actions to be taken by BMI Mount Alvernia Hospital, setting out the timetable for action and an explanation where no action is proposed.

Your report was addressed to BMI Healthcare (BMI), Royal Surrey County Hospital, Royal College of Radiologists, CQC, and GMC, being organisations that have the power to take action. Please see below responses on behalf of BMI Healthcare Limited, which have been prepared with input from BMI's National Director of Clinical Services, Group Medical Director and Group Director Clinical Governance.

Concern 1

The admission of an acutely unwell patient with pneumonia to a private hospital dealing primarily with elective surgical procedures with no HDU/ITU facilities.

The most senior doctor in the hospital, other than visiting clinicians was an RMO of unclear experience who usually has the care of more than 50 patients at any one time but can be as many as 72.

This is alongside nursing staff who have no significant grounding in resuscitation and an unclear understanding of chest drain insertion for pneumonic pleural effusions, usually having to deal with malignant pleural effusions.

Response:

Admission - For admission of a patient with pneumonia to a BMI hospital without HDU/ITU facilities, a patient's current and previous medical and surgical history is considered to confirm that they meet the criteria for admission to the hospital with no HDU/ITU facilities i.e. patients requiring level 0 – to level 1 care. It is acknowledged that clinical deterioration can occur at any stage of a patient's pathway and the National Early Warning Score (NEWS) is a tool in use to support staff in recognising deterioration of a patient at an early stage and escalate accordingly for medical assessment by the

hospital's resident medical officer (RMO) as required. Following assessment by the RMO if necessary, the patient's consultant or other relevant professional, e.g. consultant anaesthetist would be contacted for advice or asked to attend. On admission, Mr Crittall's condition was assessed to be level 0, an appropriate admission to the hospital

Resident Medical Officer (RMO) - The role of the RMO is to respond to requests from consultants and nursing staff in matters which require medical input and involves the assessment of surgical and medical patients who deviate from the treatment pathway, and deteriorating patients. RMO's are provided to the hospital by an agency and are provided on the basis that they are able to work within the clinical requirements specific to the hospital, including GMC registration, a current Advanced Life Support certificate and European Paediatric Life Support certificate and experience in cancer care. This was the case for the RMO on duty that day.

At the time of Mr Crittall's admission, the hospital was registered for 72 beds. However, not all of the patient bedrooms are in use for patient admissions at any one time and in the past 3 years, the typical in-patient occupancy has not exceeded 15 patients over the 24 hour period. On the relevant day there were no more than 12 patients admitted to Mr Crittall's ward and a number of other patients in other departments within the hospital.

Nursing staff - All hospital staff receive either advanced life support (ALS); basic life support (BLS) or immediate life support (ILS) resuscitation council accredited training. All nursing staff are ILS trained as a minimum requirement and the current senior nursing team are ALS trained with the exception of 1 member of the team. The requirement is for renewal every 4 years. In the intervening years between formal ALS training all ALS qualified staff attend an ALS refresher (previously this was an ILS, refresher).

Understanding of chest drains - While the specifics of chest drain insertion may differ according to the condition being treated, the principles for the management of a chest drain apply both to pneumonic pleural effusions and malignant pleural effusions.

In response, the following actions have been taken:

1. Any RMO's offered to the hospital are required to meet specific criteria regarding previous experience and competency and a number of RMOs have been specifically selected who are familiar with the hospital, the consultants and nursing staff with the aim of improving continuity of care and communication with consultants.
2. All staff and RMO's are involved with regular unannounced resuscitation scenarios run at the hospital by an externally appointed resuscitation training company engaged to teach resuscitation skills to all staff. Any learning requirements are identified to staff and to the RMOs and their agency.
3. All nursing staff and Health Care Assistants have attended AIMS (Acute Illness Management training) and completed competencies in the care of the deteriorating patient.
4. The protocol for the care of patients with a chest drain has been updated to align with British Thoracic Society (BTS) guidelines. Training and competencies for all radiology and nursing staff on the understanding of chest drain insertion is currently under review by BMI to be incorporated in the Acute care Competencies.
5. Following the feedback from the coroner we have further strengthened the process for the management of patients with pleural infection, utilising the diagnostic algorithm for the management of such patients as described in the BTS guidelines 2010.

Concern 2

The absence of operational protocols and a HDU/ITU facility to manage emergency situations and a reliance on 999 call for paramedics to provide care for a hospital who undertakes such procedures prior to transferring an unwell patient to an NHS Hospital.

Response:

The hospital has an Elective and Non-Elective Transfer Policy in place which sets out the requirements for transfer of patients in emergency situations. The policy acknowledges that clinical deterioration can occur at any stage of a patient's pathway. The National Early Warning Score (NEWS) is a tool to support staff to recognise deterioration at an early stage and escalate for medical assessment by the RMO. If following assessment it is deemed necessary, the patients' consultant or other relevant professional, e.g. consultant anaesthetist should be contacted for advice or asked to attend.

The consultant and their anaesthetist (where appropriate) and the senior nurse on duty are required to make the decision as to whether a patient should be transferred to a critical care unit. Those patients requiring higher dependency care will be transferred to a specified level 2 or 3 care within the Critical Care Network. If a patient is unstable and their condition is life threatening, a 999 call will be made. The content of the policy, including the process for transfer, has been agreed with the Royal Surrey County Hospital.

It is acknowledged that there was a reliance on the imminent arrival of a paramedic crew on the day in question which following a significant delay to their arrival, affected certain decisions made. However, there are facilities available at the hospital to support the stabilising of a patient prior to transfer, which on this occasion were not utilised. A number of key points to improve future management of a deteriorating patient were identified and have been addressed as set out below.

In response, the following actions have been taken:

1. The hospital's Elective and Non-Elective Transfer Policy, has been reviewed and updated to reinforce the registered level of care provided by the hospital. The process for transfer in an emergency situation was agreed with the Medical Director at the Royal Surrey County Hospital NHS Trust and incorporated into the policy. The policy is available for RMO and senior nursing staff within the RMO induction and bleep holder file.
2. A local standard operating procedure (SOP) has been agreed at the hospital resuscitation committee to reinforce the management of a critically ill patient whereby a patient is automatically transferred to the recovery area within the hospital's theatre complex to ensure access to comprehensive monitoring equipment and anaesthetic staff.
3. The SOP is tested in unannounced resuscitation scenarios which allow staff to reinforce their understanding and experience.
4. All consultant anaesthetists are aware that whilst in the hospital, the management of a critically ill patient is a priority over elective surgical cases.
5. Where required, the consultant anaesthetist will travel with the patient.

Concern 3

The insertion of a chest drain on the 4th July was not supported by British Thoracic Society (BTS) guidelines and was attempted on the background of an improving clinical picture without repeat of relevant investigations (e.g. inflammatory markers) or evidence of a developing or actual empyema or a further medical review, by either the radiologist or responsible clinician, to confirm its necessity.

Response:

The decision to proceed with the insertion of a chest drain was made by the radiologist at the request of the admitting physician with consideration of the x-ray taken that morning.

In response, the following actions have been taken:

1. The consultant radiologist withdrew from interventional radiology following this event having notified his responsible officer and the GMC.
2. Where, there is a failed sampling of loculated fluid, consultant radiologists are expected to follow the BTS guidance which requests that the consultant consider CT imaging for further image guided aspiration.
3. We have developed a pathway which provides consultants with a clear picture of the patient's clinical condition which will support any decision regarding the progression to an interventional procedure.

Concern 4

I heard evidence that the insertion of a chest drain may pre-empt difficulties that may arise if Mr Crittall deteriorated over the approaching weekend. This was contrary to expert evidence that chest drain insertion should only be considered as a necessity and should not be influenced by the day of the week.

Response:

The decision to insert a chest drain should not be influenced by the day of the week. The hospital is open and staffed 24 hours a day, 7 days a week as is the Radiology department. An on call radiographer is provided to enable procedures to be carried out whenever required. Consultants are not expected to make such clinical decisions based on the day of the week.

Consultants are expected to follow BTS guidance when making such decisions.

Concern 5

Real time ultrasound visualisation was not used to guide the chest drain insertion against 'best practice'. I was led to believe 'best practice' was not commonly used at Royal Surrey County hospital and in many other hospitals nationally. I also heard evidence real time ultrasound visualisation would have assisted the insertion as the effusion was small and lay in an awkward position close to tethering of the lung to the chest wall (which was not documented in the hospital notes or the radiologist's statement but was clearly present on ultrasound pictures examined by Dr Burkhill and acknowledged to be present by the radiologist who undertook the chest drain insertion in oral testimony).

Response:

We acknowledge the coroner's comments on best practice. We have reviewed the BTS guidance for the management of patients with pleural infection and have incorporated the guidance into the patient pathway.

Concern 6

The position of the non-draining (second attempt) chest drain was not radiologically confirmed, against expected practice, particularly as it wasn't draining. I heard expert evidence that this resulted in a delay in recognition and prompt management of the haemothorax which contributed to Mr Crittall's death.

Response:

It is acknowledged that the chest drain was not confirmed radiologically against expected practice.

In response, the following actions have been taken:

1. A Standard Operating Procedure, local to the hospital, has been developed. The procedure reflects the requirements of best practice detailed within the BTS guidance in relation to the requirement to consider a CT scan and further image guided aspiration following a failed sampling or presence of a small loculated effusion.

Concern 7

Best practice measures had not been instituted in the radiology department to safeguard patients undergoing radiological interventions. This included completion of an appropriate consent detailing complications, radiological indication for insertion of chest drain independent of the respiratory consultant, a WHO checklist, no observations (BP, HR, temp, etc.) before or after the chest procedure on a background of poor communication with the ward staff as to what plan was in place other than an outdated protocol for management of chest drains on the ward which did not address what actions to take if complications arose. It was held in court that if these steps were in place it is likely that the haemothorax would have been picked up quicker allowing greater amount of time for appropriate steps to have been taken e.g. earlier resuscitation and a direct transfer to a regional thoracic unit.

Response:

In 2014 the WHO check list for procedures was introduced into the radiology department and is now every day practice and all consultants were aware of the requirement to undertake a comprehensive consent detailing risks and benefits of the procedure. Following the incident the consultant body were reminded of the necessity to ensure that documentation is complete detailing possible complications on each consent form. This process is subject to audit which confirms compliance with this standard.

In response, the following actions have been taken:

1. Consultants have been reminded of the requirement to ensure completion of appropriate consent, the radiological indication for insertion and documentation of complications on each consent form. This process is subject to audit.
2. A patient pathway has been developed for patients undertaking this type of procedure to ensure improved communication between staff on the ward and in radiology. The pathway ensures base line observations are recorded prior to and following the procedure and requires clear communication on handover.
3. The pathway includes the protocol for the management of chest drains on the ward which addresses actions to take if complications arise.

Concern 8

The use of a 6f gauge pig tail catheter in the management of pleural effusions with or without an empyema was against both national guidelines and expert evidence heard at inquest and was unsupported by either international research or any recent local audits undertaken to justify their use in preference for larger small bore chest drains.

In response, the following actions have been taken:

1. As discussed previously in the response to Concern 6, BTS guidance for the management of patients with pleural infection is promoted which includes reference to the use of a larger bore tube size 10 – 14.

Concern 9

The court heard evidence that there was a 'local' proactive approach for the insertion of chest drains based on no objective evidence other than the belief that the very smallest catheters were safer and more comfortable and reduced referral for surgical management of an empyema. The view was against expert evidence at inquest and concern was raised that this approach inevitably led to an excess of chest drains being inserted unnecessarily particularly when BTS guidelines were not being routinely applied and/or no evidence of a developing or actual empyema.

Response:

The 'local' proactive approach described was specific to the consultants concerned based on their practice and experience. There is no evidence that any other consultants at the hospital adopted such an approach.

The consultant radiologist no longer conducts interventional work at the hospital and the consultant physician no longer admits patients to the hospital.

As previously discussed the hospital promotes management in accordance with the BTS guidance.

Concern 10

The Radiologist did not have acute or basic life support training as would be expected for all clinical hospital staff as part of mandatory NHS appointments.

Response:

All consultants are required to have basic life support training as a minimum. As part of the practising privileges that are granted to consultants to allow them to practice at the hospital, annual practice appraisals are conducted, part of which is a requirement for a consultant's responsible officer to confirm that basic life support training has been completed.

In 2014 the BMI Practising Privileges policy required confirmation of a completed appraisal whereby a consultant's Responsible Officer /Clinical Director would confirm that all requirements for the appraisal were met. Since that time an updated practicing privileges policy has been introduced across all BMI hospitals which includes a requirement that details of completed mandatory training are provided by all consultants on an annual basis.

Concern 11

There was minimal documentation by the respiratory consultant with only a brief entry in the notes on admission. There was no management plan in place, no record of any clinical examination undertaken, and no request to check inflammatory markers which had been elevated to see whether they had improved which may have assisted in the necessity for the chest drain. It appeared to be an understanding a chest drain would be sited as a joint enterprise between the physician and radiologist.

Response:

The level of documentation by both consultants was less than the standard expected and required, which in turn, did not support ward staff in the management of the patient.

The requirement is that all management plans, interventions and clinical examinations are documented contemporaneously (or as near to as possible) in the medical record.

In response, the following actions have been taken:

1. There have been a number of initiatives across the hospital in the last 2 years to reinforce the standard and ensure that all consultants are aware of the requirement to make contemporaneous notes regarding their patients.
2. Consultant input into the medical record is subject to a monthly audit on a sample basis and audit results indicate significant improvement.
3. Consultants who do not comply with the required standard are referred to the hospital's Director of Nursing and the hospital's Medical Advisory Committee (MAC) Chair and appropriate action is taken where necessary.

I would like to assure you that we have taken the concerns identified in your report extremely seriously and I trust the responses given above have addressed your concerns. May I also take this opportunity to again express our sincere apologies and condolences to Mr Crittall's family.

Yours sincerely



Executive Director