Tameside Hospital NHS
NHS Foundation Trust

Quality & Governance Unit
Tameside General Hospital
Fountain Street
Ashton-under-Lyne
Lancashire
OL6 9RW
Tel: [redacted]

Miss Joanne Kearsley
Acting Senior Coroner for Manchester South
The Coroners Court
1 Mount Tabor Street
Stockport
SK1 3AG

22nd August 2016

Your Ref:

Dear Miss Kearsley,

Re: Regulation 28: Report to Prevent Future Deaths following inquest into the death of David Little (Deceased)

I write further to Mr Pollard's letter dated 29 June 2016 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching upon the death of David Little, which took place on 28 June 2016. I am, of course, very sorry that Mr Pollard had cause to issue this report.

I hope to be able to address these concerns, as set out in Section 5 of the report, to your satisfaction, in this letter. I have addressed the areas of concern, adopting the same number in Section 5 of the report as follows:

1. *There was strong evidence of a failure by the hospital staff to keep clear records of when an inpatient was to be taken to "radiology", for what purpose, whether the patient had been returned to the ward. In the present case, Mr Little was taken 'by mistake' in the belief that he was another patient, and it was only on arrival at radiology that this was realised when they decided to proceed with his scan which had been planned for the following day.*

Further investigation has revealed that the computer records from the Radiology CRIS system show that the request for Mr Little's CT scan was made at 11:29hrs on 10 June 2015 and the request was actioned at 11:33hrs on the same day. At this time the appointment was scheduled for 15:30hrs on the same day and Mr Little attended at 15:29hrs. The CRIS system does not show that he was initially scheduled for the following day. Therefore, in terms of whether Mr Little was taken 'by mistake', this does not appear to be the case as Mr Little was expected in the department at 15:30hrs on 10 June.

On reviewing the evidence given by the family and [redacted] at the inquest, it is clear that there was certainly some confusion about when his scan was due to be performed and it is accepted that it was likely poor and confusing communication between the Radiology department and the ward/clinicians that was the root cause.

When a request is required very urgently for a patient, as was the case with Mr Little, prior to the request being accepted by Radiology to prioritise the patient, it is mandatory for the clinician to phone the department to discuss the clinical urgency with the Radiologist of the day. This is to ensure that the correct clinical priority is assigned and that the patient receives the required input from the radiologist to ensure the most appropriate investigation is requested for the presenting condition. It is noted that this process of communication with the ward following the acceptance of the scan by the Radiologist of the day may have been the source of confusion. This likely took place before the scan request was placed on the system, at which point, a slot had been found for Mr Little that day, but this did not appear to have been communicated to the ward or clinicians.

Following Mr Little's death, the department has published a 'Radiology Requesting and Reporting Policy' in February 2016 (Document 1 attached). The Policy requires the clinician to document the discussion in the clinical notes of the request made to Radiology and the response given. Once the scan is requested, the Radiology department must then ensure that they document any changes to the planned appointment and communicate them with the responsible clinician. It is clear that at the time of Mr Little's death, the communication appeared to be confusing and there are insufficient documented records to confirm what conversations actually took place at the time.

In addition, there is currently a documented tracking/handover policy in draft (Document 2 attached) which will document any specific requests that are given to the patient via the ward staff to prepare them for their investigation, e.g. nil by mouth or the requirement for a full bladder. It will include a feedback form that the porter will take to the ward when collecting the patient for a member of the nursing staff to sign to confirm the patient's identification and the test/imaging the patient is scheduled for. On return of the patient to the ward, the sheet will document what investigation has taken place and any special observations required. This form will form a part of the radiology record and be filed in the patient's notes.

It is anticipated that both these processes together will ensure that the responsibilities of both the requesting clinician and the Radiology department are clear, there is better communication between Radiology and the ward staff/requesting clinicians, and that the communication is documented and auditable.

2. *The hospital had no clear diagnostic pathway or monitoring plan on admission, the staff appeared not to be trained to recognise the symptoms of a blocked bowel not the potential seriousness thereof not to be aware of the dire consequences of failure to diagnose and treat appropriately.*

The Trust has devised a small bowel obstruction surgical pathway (Document 3 attached) which now describes the pathway and monitoring plan for this patient group. Learning undertaken following Mr Little's death has been incorporated into this pathway. It has been agreed by the surgical, nursing and clinical teams and will be ratified as described in the document, through the governance forums in General Surgery, Radiology, Urgent Care & Critical Care before being signed off at Trust level by the end of September.

3. *Where there is a differential diagnosis of two or more potential conditions, the staff simply treated the least serious and assumed that was the correct diagnosis rather than taking the most serious and working backwards from that standpoint.*

The pathway described in point 2, addresses the appropriate consideration that should be given to various clinical conditions and their clinical priority.

4. *The communication between and among staff generally was poor but especially between the radiology department and the clinicians and nurses. There was little or no*

good communication with the family which led to additional distress for them at a time of great sorrow.

The Trust sincerely apologises to Mr Little's family. The response to point 1 is anticipated to significantly improve the communication between the radiology department and the clinicians and nurses.

The Trust have invited the family to discuss their concerns directly with the Trust and are more than happy to involve the family with ongoing learning in order to improve on general communication with family members.

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

Yours sincerely,

Karen James
Chief Executive

cc. NHS Improvement
CQC
Tameside and Glossop CCG