Barnsley Hospital Quality in Care

Barnsley Hospital NHS
NHS Foundation Trust

Direct contact:
Tel: [redacted]
e-mail: [redacted]

Gawber Road
Barnsley
S75 2EP

Tel: 01226 730000
Fax: 01226 202859
Minicom: 01226 321014

4 January 2017

Mr C P Dorries
Senior Coroner
South Yorkshire West Area
Medico Legal Centre
Watery Street
Sheffield
S3 7ES

Our Reference: RJ/KAD - Captain Bedforth
Your Reference: CPD – Regulation 28 – Captain Bedforth

Dear Mr Dorries

Captain James Bedforth Inquest - Regulation 28 Prevention of Future Death Response

I am writing in response to your Regulation 28 Report to Prevent Future Deaths received at the Trust on Tuesday 25 October 2016 relating to the inquest of Captain James Bedforth.

Regarding our response I will follow the same numbering as set out in your report, I will not set out each of your concerns but respond to them below.

1. The current NICE guidance for Venous Thromboembolism advises proximal leg USS investigation for those patients who are high risk based on Wells scoring and those who are low risk with a positive D-dimer. If negative, the patient should undergo a second proximal leg USS in 6-8 days time to exclude proximal propagation of a clot from a distal DVT. The rationale behind the NICE guidance is evidence-based following multiple studies.

The hospital has decided it will not change its processes on the basis that in Captain Bedforth's case it would be more likely than not that the distal leg USS would not have had any impact as distal leg USS does not detect all DVTs that are present. No combination of tests can rule out disease in 100% of cases and a lower leg scan may also have been falsely reassuring. It is evident from this particular case that consideration could have been given for treating Captain Bedforth despite the normal USS given that this case may be one of that small minority of cases where USS is falsely negative. However, treating patients without confirmatory evidence of a DVT creates a separate set of risks as this would expose significant numbers of patients to unnecessary anticoagulation.

In relation to your concern regarding the discharge of a patient like Captain Bedforth following a negative scan and whether he requires close supervision by a doctor, this practice is already in place and is triggered by the Thrombosis nurse. The process is that if the Thrombosis Service Sister has concerns regarding a patient they are referred to the consultant for review in the DVT clinic. The Thrombosis Sister has stated that Captain Bedforth's case is the first case of its kind she has been aware of in the last 15 years. We will be interested to see whether national guidance changes following your letter and would adapt our local guidelines accordingly, if so.

2. There is a Patient Information Sheet for patients who have attended hospital for investigation for deep vein thrombosis or pulmonary embolism. (*Attached*) This sheet is handed to all such patients at discharge, along with verbal advice provided by our specialist nurses. The Thrombosis nurses now record in their notes that an information sheet has been given to the patient. This will be audited to assess compliance.

3. In the Emergency Department (ED) there is now a consultant in the new assessment hub area, which should speed up the diagnosis and management of someone presenting in this way. The Short-Term Assessment of Risk and Treatability Hub (START) runs between the hours of 09:00 and 16:00 hours and is consultant led. The START consultant will provide a senior 'front of house' service to assist with the initial assessment and ensure the appropriate diagnostic testing is undertaken at the earliest opportunity. The Consultant will work alongside the assessment hub staff in ensuring a safe and rapid assessment process. The consultant predominantly receives patients arriving by ambulance, however patients that also 'self present' can be seen on START, if they are unwell, have an elevated NEWS score or require treatment within one hour.

4. We have and continue to ensure there are sound processes in all clinical areas regarding prompt escalation of unwell patients. This is covered on the induction programme for all medical students who are very familiar with the need to escalate if they see someone who is acutely unwell. We have also recently introduced an Acute Response Team of Advanced Nurse Practitioners who rapidly attend to support wards with patients who deteriorate. We have also invested in the VitalPac electronic observation system that has been demonstrated in other Trusts to improve the recognition and response for sick patients.

5. The Trust has altered the Thrombolysis PE guideline – amongst the changes we have addressed the concerns about checking whether heparin had been administered previously and to carefully check and monitor the APTT ratio. A copy of the revised guidance is attached for your information

In relation to your query surrounding the time taken for sampling to be delivered to the laboratory and provision of the result, this query was covered in the Serious Incident (SI) investigation report and I quote that part of the SI Report for your assistance.

> "The sample for APTT testing was timed as being collected from ICU at 19.58hrs, but the sample was not taken until 21.15hrs and not received by pathology until 21.24. The results were reported to ICU at 22.35hrs, so an apparent delay of 2 hours and 37 minutes seemed to have occurred.
>
> However, when the Lead Nurse on ICU was asked about this as part of the SI investigation, she explained that ICU staff pre-prepare for testing of bloods, which was why the test indicated the time 19.58hrs."

This means that the form was completed in advance at 19:58 hours and the time taken from collection to report was actually 1 hour 20 minutes not 2 hours 37 minutes.

6. The new Thrombolysis protocol (see point 5) prompts the doctor to ensure that heparin hasn't already been given, for example in the ED. We aim to introduce an electronic prescribing system in 2017 that would allow doctors to more easily identify what drugs have already been given.

I hope the above is of assistance, if you wish to discuss this matter please do not hesitate to contact me.

Yours sincerely

R. Davis

[redacted]
Medical Director

Enc