Salford Royal NHS
NHS Foundation Trust
University Teaching Trust

safe • clean • personal

CHIEF EXECUTIVE
Sir David Dalton

Telephone: [redacted]
Email:

STRICTLY PRIVATE AND CONFIDENTIAL

Mrs Rachael C Griffin
Assistant Coroner
Coroner Area of Manchester West
Ground Floor
Paderborn House
Howell Croft North
Bolton
BL1 1JW

Dear Mrs Griffin

Re: Mr Gordon Arthur (Deceased); Regulation 28: Report to Prevent Future Deaths to Salford Royal NHS Foundation Trust issued on 25th January 2017.

I was very sorry to hear that you had concerns about future preventable deaths. You requested that Salford Royal NHS Foundation Trust consider your concerns in relation to:

The lack of policies dealing with the process of investigative tests and the notification of their results to Consultants in charge of a patient's care could lead to patients not being given the treatment they require, which could result in a future death. I therefore request that you review the policies and procedures relating to investigative procedures and the reporting of their results to the Consultant in charge of the patient's care in order to prevent a future death.

Following receipt of your letter the Clinical Director for Radiology and the Clinical Director for the Orthopaedic service carried out a joint review of the current trust policies in relation to the ordering of radiological investigations and how the results of such investigations are communicated to the requesting clinicians.

The current process in the trust dictates that it is the responsibility of the Clinician requesting the investigation to

1. Detail the clinical picture on the request card,
2. Review the results and
3. Coordinate the care pathway depending on the information.

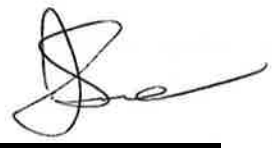
It is clear that channels of good communication are needed to ensure that this system is effective. The review confirmed that Salford Royal NHS Trust has the following protocols in place;

- Radiology Rapid Notification of a New Unsuspected Pathology (NUP) Suggestive of a Diagnosis of Cancer Policy Unique ID: TWCR01(15)
- Standard Operating Policy: Alerting Clinicians to Unexpected Urgent or Life Threatening Findings on imaging

In order to ensure that all members of the consultant body have knowledge of these protocols and their contents, they have been disseminated by email and have been discussed at the Orthopaedic clinical governance meeting on the 29th March 2017.

I hope that this response provides assurance to yourself and Mr Arthur's family that the Orthopaedic and Radiology department at Salford Royal have worked collaboratively to ensure that results following radiological investigation are communicated and reviewed in a timely manner to the medical teams coordinating the patient's care in order to support the appropriate treatment plan. I hope the Action Plan provides you with the assurance that the Trust takes patient safety issues very seriously and is taking appropriate action to mitigate any future preventable deaths.

Yours sincerely



[redacted]

Chief Officer