The Royal Wolverhampton NHS
NHS Trust

JO/LNR

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Private and Confidential
For the attention of Mr Z Siddique
HM Senior Coroner
Black Country Coroner's Court
Jack Judge House
Halesowen Street
Oldbury
B69 2AJ

19 July 2017

Dear Mr Siddique

RE: PATIENT SARAH POOLE – DECEASED - HOSPITAL NUMBER H19006 DOB 01/03/1978

Firstly, please may I express my condolences on the death of Sarah Poole.

I write this letter in response to the regulation 28 report to Prevent Future Deaths dated 30th May 2017.

The concerns raised at the inquest on the 4th April 2017 relate to Miss Sarah Poole, and are that there were failures to record and endorse the name of the Doctor reviewing the ECG and the failure to take into account previous abnormal ECG results.

The Emergency Department has instigated a policy that all ECGs must be reviewed and signed off by a Senior Decision Maker, i.e. a middle grade Doctor or Consultant.

This policy will be audited on a monthly basis with 20 sets of ECGs being reviewed to ensure that each ECG has been signed off by a Senior Decision Maker and also to audit whether documentation relating to the ECGs is being made in the patients notes.

We have just completed the audit for June 2017 and this shows a 100% compliance with a Senior Decision Maker signing and reviewing the ECG, and 90% compliance with documentation being made in the notes. Where there have been omissions the individuals concerned are identified and advised of the requirement to comply with the measures. However, if they persist in not complying then the Trust will instigate misconduct proceedings.

The department has also developed an algorithm for how to manage an abnormal ECG, which has been approved by the Consultant Body and will be taken to the departmental Governance Meeting for ratification and will be in place for the next Junior Induction in August 2017. This process will be reinforced during a "Focus Fortnight" for Nurses during July 2017. Also, the message will be delivered using the Departmental Safety Briefings twice daily as a way of reinforcing the new process. This will also be backed up by posters describing the new process.

With regards to the ambulance handover there have been problems with the new electronic handover system producing lengthy documents. However, we have now introduced a way of summarising this information into 1 to 2 sheets which will be printed off and attached to the ED patient documentation. To ensure that medical staff review this information we have included in the discharge checklist (shared at the inquest) a statement which will ask the clinician to confirm that they have read the pre-hospital information. The checklist has been agreed by the Senior Team in ED and is in the process of being incorporated electronically into the printed element of ED patient documentation. We cannot confirm at this time the exact implementation date but it will be within the next month, and along with the ECG process we plan to audit the compliance with the discharge checklist on a monthly basis.

Please let me know if you require any additional information.

Yours sincerely

Dr Jonathan Odum
MEDICAL DIRECTOR