

Office of the Medical Director

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28 January 2018

Mr Paul Cooper
Assistant Coroner Lincolnshire
[Via email]

Re:- BREISLIN DOROTHY, Ref: INQ/4903

Dear Mr Cooper

I write further to your Regulation 28 Report to Prevent Future Deaths following the inquest into the death of Mrs Breislin.

Matters of concern

1. The incident date was 27 January 2015. The incident review report was not received in this office until 10 August 2017. Why the delay?

I can only apologise for the unacceptable delay in not only recognising that this was an SI but for the delay in forwarding the final report to you. The Trust recognises that the SI process at that time was poor. We are working hard to clear our backlog of SI reports, which is being overseen by myself and the Director of Nursing and we are also implementing a new SI process. This incorporates training across the Trust on undertaking SI investigations.

We currently have an Interim Director of Governance in post who is leading on this project and a new Risk Manager will be starting in February 2018.

Whilst this is a work in progress, I hope you will be assured that the Trust is striving towards a much improved SI process.

2. S13 recites an apology has been provided verbally and in writing. The family asks who made the apology. Also when and where as they are adamant they have never received one.

This Duty of Candour section is what should have happened. I have no evidence that any verbal apology was made and indeed a written apology should have been done, but was not. Again, I can only apologise that what we should have done was

not done.

3. [REDACTED] confirmed on oath that none of the Action Plan referred to in the Appendices at 3 have been implemented. If not, in view of the incident date, why not?

The VTE Nurse Manager and the Consultant Haematologist met up in August 2017 to discuss the changes and these were agreed. This was to be discussed at the September 2017 Thrombosis Committee meeting but the meeting was cancelled as both the Chair and Vice Chair were unable to attend. Unfortunately, due to an oversight the matter was not put onto the November agenda.

This was picked up in December 2017 when the form was sent to [REDACTED] (Consultant Physician) to update the clerking proforma risk assessment. I understand that the updating clerking proforma was to go to print and be available for use in January 2018. I have been advised that the revised risk assessment will be sent to Stores to re-print on Monday 29 January 2018 and then be circulated to the clinical teams.

Yours sincerely

Neill Hepburn

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Medical Director