- 2 JUL 2018

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Mrs J Lake
HM Coroner for Norfolk
Carrow House
301 King Street
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Dear Mrs Lake

Response to Regulation 28 report

Further to the Regulation 28 Report dated 9th May 2018 I am pleased to respond as follows to the matters of concern you raised in your letter.

(1)

Upon the patient's admission the admitting consultant, [redacted] wrote in his management plan that Kirsty was to have daily bloods. That plan clearly varied subsequently but his initial plan was based upon his clinical assessment at the time. I think it is important to note that our admission document (Clerking Proforma) is not regarded as a rigid tool, perhaps as is seen with documentation like the Waterlow assessment or falls risk tools, for example. From the medical point of view the plan may, and should, change as different doctors subsequently review the patient and or the condition or working diagnoses change. In fact I would expect subsequent doctors visiting a patient always to have in mind an inquisitive and challenging approach to initial working diagnoses and management plans, and be prepared to alter them. There are times when the patient condition, working diagnosis or even opinions of the attending physician may be at variance with views expressed in an earlier consultation during an admission. However, it is not standard practice to formally deal with each of the previous medical entries; unless perhaps there was a serious reason to question the validity of the initial opinion, which there wasn't in this case.

I have taken counsel from a number of physicians on the facts of this case, each of whom would have managed the case slightly differently as it unfolded. I wonder if this contributed to the sense there was an evidential vacuum. For example, if other doctors had been called, they may well have given other different views on the same facts. With the benefit of hindsight I suspect this is also the reason why it was difficult for us to anticipate how to provide the best information for you beforehand. Please be reassured that this organisation will continue to strive to provide all necessary information to the Coroner in her investigations and deliver the best possible assistance on the day in court.

(2) and (3)

The Trust currently uses the Early Warning Score (EWS) system to detect early signs of a patient's deterioration. On this occasion the readings were not adequately recorded and the appropriate escalation did not occur in a timely fashion.

The staff, both nursing and medical, working in that clinical area have received support to ensure that they understand and are able to use the current escalation system.

The Trust recognises however that a wider and more comprehensive review is needed to ensure that early warning systems are consistently in place across the whole Trust.

The Trust has therefore decided to bring forward plans to adopt the National Early Warning system (NEWS2) that is mandated across the NHS from April 2019 and will implement this on November 1st 2018.

This will necessitate new documentation, training and escalation procedures and, in order to avoid confusion, the Trust has decided not to undertake widespread retraining on the older escalation procedures between June and November 2018. Our timetable is set out below:

May 14	Agreement to adopt NEWS2 on 1 November 2018
May 16	Appointment of NEWS2 Champion
June 11	NEWS2 Implementation Group formed with reporting to Trust Clinical Governance Committee
September 1	Countdown to NEWS2 (communication and training)
November 1	NEWS2 go live

This will be followed by an ongoing audit to ensure appropriate documentation and audit of escalation.

Please let me know if you require any further assistance.

Yours sincerely

Dr Nick Lyons
Medical Director

on behalf of Jon Green, Chief Executive Officer