Scanned + Sent 2.7.19.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Salford | Oldham | Bury | Rochdale | North Manchester

Ref: CB HMC3395

Date: 2 July 2019

Chief Medical Officer/Deputy Chief Executive
Group Headquarters
3rd Floor
Mayo Building
Stott Lane
Salford
M6 8HD
Telephone: 0161 206 4657

Mr Cox
HM Assistant Coroner
Office of HM Coroner
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

Dear ~~Mr Cox~~ Mr Cox,

Re: Mrs Deborah Anne Hopkinson

I am writing to you, in response to your Regulation 28 report dated 24 April 2019 regarding the death of Mrs Deborah Anne Hopkinson who sadly died following an admission at Fairfield General Hospital. At the outset, I should be grateful if you would pass on my sincere condolences to the family of Mrs Hopkinson, I was sorry to hear that they have been given cause for concern at such a difficult time.

Thank you for bringing the concerns raised in the Regulation 28 report to our attention. The Trust is dedicated to ensuring patient safety is maintained throughout all services. I would like to take this opportunity to provide assurance to both you and the family that the Trust takes the concerns raised very seriously and has conducted a thorough review.

Your concerns were as follows:

1. *Equipment failures which were likely to have had some impact on Mrs Hopkinson's admission, namely:*

    a. *When Mrs Hopkinson was re-admitted to hospital on 12 September 2018 there was a delay of six days in involving the endocrine consultant at Fairfield Hospital due to the computer system being down;*
    b. *The analyser for running cortisol samples was down multiple times during Mrs Hopkinson's admission;*
    c. *There was a significant deterioration in Mrs Hopkinson's condition during the evening of 25 September 2018 but a CT abdomen could not be performed due to the CT scanner at Fairfield General Hospital not working;*
    d. *When Mrs Hopkinson's case was discussed at an MDT meeting on 13 September 2018 the MRI scan could not be viewed on the PACS system.*

2. *While it was not possible to say on balance that these altered the outcome, there were delays in obtaining advice from a specialist centre such as Salford Royal Hospital or the Christie Hospital as follows:*

   a. *Delay in referral to Salford Royal Hospital between 21 and 28 August 2018 following an MRI scan which revealed pituitary adenoma;*
   b. *Delay in seeking advice from specialists between 12 and 17 September 2018 and an accepted delay in treatment for probable pneumocystis pneumonia.*

In order to address each concern I have answered them as they have been written in your letter.

Equipment failures

- **IT systems**

The Trust acknowledges and apologies that there was a delay in [redacted] being made aware of Mrs Hopkinson's readmission on 12 September 2018 and that the multi-disciplinary team (MDT) was not able to view the MRI scan when it met on 13 September 2018 due to a Trust-wide failure of the IT systems during this time.

There has been a subsequent Root Cause Analysis investigation into the incident and the source of the problem was identified as a combination of equipment failure, required software reconfiguration and a broadcast storm.

The risk of recurrence of these issues has been addressed by replacement of the IT equipment, completion of the software reconfiguration and installation of filtering equipment.

- **Cortisol analysers**

The Trust acknowledges that there were difficulties with the cortisol analysers during Mrs Hopkinson's admission and I refer to [redacted] Consultant Haematologist's statement in order to offer assurance that the Trust has learnt from this.

As a result of the concerns, cortisol analysis was added to the test repertoire at Fairfield General Hospital on 7 January 2019 and to two further analysers at North Manchester General Hospital on 7 February 2019.

This will reduce the turn-around time for results by removing the transport time, as well as increasing resilience. The Trust expects that samples that need urgent processing would indicate that the results were needed urgently and if urgent samples are not able to be processed locally, the team will continue to transport them to other sites as has occurred in previous cases.

- **CT scanner**

The Trust apologises that the CT scanner at Fairfield General Hospital was not working on 25 September 2018.

There are continuity plans in place for all CT scanner downtime and a comprehensive contingency plan, which was re-circulated to staff on 26 September 2018 in order to manage the downtime at Fairfield General Hospital. Sadly, Mrs Hopkinson was not well enough to travel to North Manchester General Hospital for a CT scan on 25 or 26 September 2018.

In order to improve patient safety, the CT scanner at Fairfield General Hospital has been replaced. During the replacement works, a temporary mobile scanner was on site and in future it will also be possible to bring in a mobile scanner in case of downtime or in the event that additional capacity is required.

- **Referral to Salford**

The concern in relation to a delayed referral to the specialists at Salford Royal Hospital was not raised at the hearing itself, nor in the conclusion and I have therefore sought additional input from [redacted] who was the treating consultant at the time in order to provide assurance around this point.

The MRI scan reported on 21 August 2018 showed pituitary adenoma. [redacted] explains to me that as 10% of the population have a pituitary adenoma that is often non-functioning, it is important to confirm a diagnosis of Cushing's disease biochemically in order to avoid unnecessary surgery to a patient. For this reason, a 48 hour dexamethasone suppression test was needed along with testing of ACTH levels and this was completed between 22 and 24 August 2018. The results were reviewed by the Registrar on 28 August 2018 and discussed with Salford on the same day, with a referral to MDT and neurosurgeons following this. Cortisol lowering medication was also started the same day.

Involvement of the Christie & treatment for PJP

It is accepted that there was a delay in [redacted] becoming involved and seeking further advice from specialists when Mrs Hopkinson was re-admitted on 12 September 2018, due to the IT system downtime as addressed above and the Trust wishes to sincerely apologise to Mrs Hopkinson's family for this.

In addition to resolving the IT issues that led to the delay in [redacted] being notified of Mrs Hopkinson's readmission, the Trust has issued a patient care alert to all staff across the Northern Care Alliance Group. The alert raised awareness that this rare disease (Cushing's Disease) increased the risk of pneumocystis pneumonia and highlighted that this should be taken into account when managing patients with Cushing's disease.

To further disseminate the learning from this investigation this case was discussed in Morbidity & Mortality meetings held by both the medical and ICU teams. In addition, the case was discussed in detail at a Clinical Governance meeting on 19 March 2019, when the patient safety alert and learning from the RCA was covered again.

These discussions covered the risk of pneumocystis pneumonia in Cushing's Disease and that this should be considered based on initial radiology. If in doubt, the team should request a sputum sample to assess for pneumocystis pneumonia and consider prescribing septrin for this.

Awareness of Cushing's Disease is also included in the annual training for Core Medical Trainees. Dr Smithurst will ensure that the consultant delivering this training is aware of this case and ensure that all trainees are aware that due to the immunosuppression that occurs in Cushing's disease and Cushing's syndrome, patients are at risk of atypical infections, including pneumocystis pneumonia.

Trainees will also be reminded of the need to refer to the endocrine team urgently if they suspect Cushing's, or if they are dealing with a patient already diagnosed with the condition. Consideration will be given to using this case as a specific case study to further future learning.

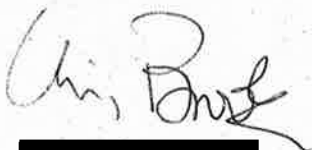
[redacted] will also discuss this case at the local endocrine MDT and send a synopsis of the case to her colleagues in advance of this, to aid discussion. [redacted] will also feed this case back to the Salford Royal MDT meeting in order to further disseminate learning.

I do hope that this response provides assurance to you and Mrs Hopkinson's family that Northern Care Alliance has worked hard and continues to focus on ensuring that lessons have been learned and improvements have been made.

I would like to conclude by apologising to Mrs Hopkinson's family for the issues in her care that have been highlighted above and assure the family that lessons have been learnt.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours sincerely



[redacted]
Consultant Emergency Medicine
Executive Medical Director, Salford Royal NHS Foundation Trust
Chief Medical Officer and Deputy Chief Executive Northern Care Alliance
(Incorporating Salford Royal NHS Foundation Trust and Pennine Acute NHS Trust)