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Mr John Gittins
Coroner
HM Coroner's Office
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Ein cyf / Our ref: [redacted]
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Dyddiad / Date: 7 September 2021

Dear Mr Gittins

Re. Regulation 28 issued in relation to the death of Mrs Rhian Margaret Roberts (D.O.B 06.08.1970 D.O.D 25.11.2020)

Further to the Regulation 28 issued by yourself on the 14th July 2021 in relation to the death of the above named patient, please find below the Health Board's response to your matters of concern.

1. *On arrival at ICU the clerking-in doctor requested a toxicology screen to include paracetamol and salicylate levels (notwithstanding that blood tests to include this were already in hand) and there was no evidence available at the inquest to establish whether or not the toxicology screen requested by the doctor was undertaken and if not why not.*

   The request for the toxicology screen to include paracetamol and salicylate levels was documented in the doctor's clerking proforma but this was not undertaken. The usual admission blood tests, (full blood count, urea and electrolytes, coagulation screen), were undertaken but not the additional tests that were documented in the management plan. We have been unable to establish why this did not happen as usual practice would be that the doctor would verbally communicate to the Nurse looking after the patient if any additional investigations were required.

   Following this incident, it was added to the Intensive Care Unit (ITU) safety brief for 2 weeks that the doctors must verbally communicate anything specific required. The Nurses have also been informed that they must check the management plans if they have been away from their patient e.g. for a break, as an additional measure to reduce the risk of missing something that has occurred in their absence.

2. *An internal investigation by the health board following Mrs Roberts' death rightly established that action needed to be taken to update or modify the SOP for communicating of life-threatening blood results directly with clinical areas and an action plan indicated that this would be completed by the 30th of June 2021. At the time of the inquest on the 13th of July, the proposed update remained in draft form only and had not yet been approved.*

   The Standard Operating Procedure (SOP) for telephoning reports and results was updated, approved and active as of the 20th July 2021 and discussed in the team brief meeting.

An annual audit is undertaken on the telephoning of results, which monitors compliance with phone log record keeping. Historically we have only asked for staff to record the name of the person taking the results, however following this incident we will mandate that staff record the name and role of the individual taking the results.

In addition to this, the current procedure to mitigate risks due to failure to act on diagnostic results (MD23) has been discussed in the 'Results Management Project Board' chaired by the Interim Secondary Care Medical Director Dr Gary Francis. The project board are reviewing the procedure with a timescale to be updated as required, approved and active by the 1st October 2021.

A business case for a desktop application and dashboard has also been approved in principle to improve the assurance for the management of results across the Health Board. This is a key development to enable us to safely rely on notifications and electronically sign off results. Results management will be delivered alongside the Digital Health Records project under the Patient Record Transition Programme, which grounds itself in the space of improving patient care through the safe transition from paper to digital reports.

3. *I am concerned that the continual delays in investigating adverse incidents, sharing learning and implementing actions following the same, create risks to patient safety.*

A new process to support the services to deliver timely investigations was commenced in April 2021. This process will improve performance and ensure investigations are robust, proportionate and timely.

A daily review panel is led by the Corporate Patient Safety Team and attended by governance leads from across the Health Board. All level 3-5 incidents (moderate, major and catastrophic severity) are reviewed to determine which are classed as serious incidents in line with the national Serious Incident Framework. This panel will commission serious incident reviews (SIRs) and determine the appropriate level of complexity of investigation and level of objectivity. An investigating officer is appointed alongside a Senior Reviewer who provides direction to the investigation whilst supporting and directing the investigating officer role.

A weekly executive panel scrutinise and confirm or amend decisions made at the daily panel to ensure direct executive oversight. This executive panel is led by the Executive Director of Nursing and Midwifery and Executive Medical Director. In the event a particularly serious or notable incident occurs, a Rapid Serious Incident Learning Panel is held within 24 hours. This panel will be led by a clinical executive and it is expected that senior divisional representatives and the clinical leads for the service will attend to agree on the immediate steps being taken to ensure safety and learning across the organisation and to discuss any immediate support. These panels are opportunities to reflect and learn and to ensure any immediate steps are taken to prevent a similar incident and to ensure staff who may be affected are also supported

The involvement of patients or their families will be strengthened. It is expected that the investigator and senior reviewer contact the patient or family at the commencement of an investigation to agree the terms of reference, agree their level of involvement in the investigation and how they wish the findings to be presented.

Depending on the complexity of the incident, investigations are required to be completed within 25 to 45 working days. Any extensions must be requested in advance from the Associate Director of Quality Assurance. The progress of the investigation is tracked via a weekly governance report that is scrutinised in directorate weekly governance meetings.

Once complete, local scrutiny of the investigation report is undertaken to ensure factual accuracy, thoroughness of the investigation, quality of the report and approval of the action plan. Once this local sign off is completed, the report will then be reviewed and scrutinised at an organisational Incident Learning Panel.

All actions arising from a serious incident investigation will be uploaded to the Datix incident system on final approval of the investigation by the Corporate Patient Safety Team. Services will upload evidence of completion when closing actions. The timely closure of actions will become a performance measure and audits will take place of submitted evidence to ensure quality and learning.

Finally, we are strengthening the sharing of learning by developing a learning portal, lessons on a page, digital sharing of learning and a monthly lessons learned event. To support the new processes, a comprehensive training passport is being finalised. This passport consists of modular courses to develop skills as an investigating officer or senior reviewer. A mentor scheme, drop in support sessions and an ongoing community of practice will also be launched. The application of human factors skills will be a key element of this training.

This new process underpins the fundamental principles we wish to establish for serious incidents: the active involvement of those affected (patients, families and staff) in the investigation, the timely completion of high quality investigations and the implementation of meaningful improvements.

If you require any further information or wish to discuss this, please do not hesitate to contact me.

Yours sincerely

[redacted]
Dirprwy Prif Weithredwr
Deputy Chief Executive