NHS
County Durham
and Darlington
NHS Foundation Trust

Executive Corridor
Darlington Memorial Hospital
Hollyhurst Road
Darlington,
DL3 6HX
[redacted]

29th April 2022

[redacted]

Mr Derek Winter
HM Coroner,
City Hall,
Plater Way,
Sunderland
SR1 3AA

Dear Mr Winter

Re: Alan Hodgson

We are writing in response to the Regulation 28 Report to Prevent Future Deaths, which you issued to County Durham and Darlington NHS Foundation Trust on 3rd March 2022. You raised six matters of concern and we will respond to each of these and detail the actions taken by, or underway at, County Durham and Darlington NHS Foundation Trust.

In addition to this, the updated action plan from the initial patient safety investigation can be found within Appendix 1 – Updated Patient Safety Incident Investigation Action Plan

1) *Signing and administration of opiate analgesia to a patient without any evidence of ascertaining why such analgesia was required, and if it was appropriate;*

The Trust review showed that the patient should not have been prescribed or administered Oramorph without a pain risk assessment and a clinical assessment by the prescribing medical member of staff.

The Trust's pain management policies outline that a pain risk assessment is to be carried out by the nursing staff and should be referred to when requesting additional pain relief. Any necessary medication should then be prescribed/administered using the Pain Risk Trust Acute Pain Algorithm. These assessments should be undertaken alongside a physical assessment and recorded on the Trust's system Nervecentre. Future improvements underway to support the management of patients pain, as part of the Trusts Electronic Patient Record (EPR) implementation, are that these assessments would automatically trigger the appropriate care plan to be put in place for the patients and support the nursing staff with adherence to policy. This will be in place when the EPR goes live in October 2022.

The learning for this patient's case, alongside the relevant policies, has been shared with the staff involved to aid their own reflective practice and a Trust wide reminder will be circulated to accompany the learning from this incident. This will also form part of a patient story 'case

study' that will be shared at Senior Nurses meetings, Sisters away days and Medical forums with consent from the patients family.

2) *Failure by the on-call Registrar to review a patient in the early hours of the morning when called for advice by the FY1 doctor;*

To ensure learning is embedded across the Organisation to prevent future risk of death a patient story is being compiled (with family consent) which highlights the key learning in this case, including the need for senior review and onward escalation. This will initially be presented to both the Medical Speciality meeting and the Junior Doctor workshop to extend learning to their colleagues, and will then be utilised in all Deteriorating Patient and Resuscitation Training sessions. The frequency of this training and the clinical staff that this will reach is described in greater detail in point 3 of the updated action plan (Appendix 1).

In relation to the individual members of staff involved in the care of this patient, the Registrar has reflected on their involvement in the patient's care, and this has been included in their revalidation portfolio. They have also discussed the case with their clinical/educational supervisor. The Foundation Doctor has confirmed that they have also met with their supervisor and also reflected on the case, they have since said that they have learned a lot from the case.

3) *Failure by a Consultant Physician to follow an established Vascular Pathway despite clearly recognising the correct diagnosis of acute lower limb ischaemia;*

The Trust has committed to providing education on the Vascular Pathway to Junior Doctors and therefore it has been included in the Trust induction programme and the training sessions for the rotational Foundation Doctors. The training need will also be shared with the Medical and Nursing School Dean's to ensure the pathway is included within pre-registration training if not already.

The Trust has also included the vascular pathway within all Care Group Governance meetings, ensuring that any key policies/updates are discussed and then disseminated.

As previously mentioned in point 3 of this letter a patient story case study will be included in all Deteriorating Patient and Resuscitation Training.

To further increase the awareness of the pathway, as part of a service improvement initiative, a plan has been put in place to develop a stand-alone e-learning package for vascular emergencies which will be updated as required in line with any changes to the pathway. This will be in addition to the mandatory training for staff to access for further education and development. A simulation scenario, to include the key learning themes, is also being developed and will be included in the Trust simulation sessions once available.

4) *Poor communication between medical and radiology doctors resulting in; delays in CTA being performed; inadequate imaging being performed; and a complete lack of urgency in reporting the findings of the CTA to the requesting doctors*

The Radiology manager confirmed following the RCA that there were site pressures at that time that the CTA was required, and that 13 other patients required scanning between the request time and scan time for this patient.

At the time that the incident occurred staff were reminded to follow the duty radiologist system and to agree the level of urgency upon discussion with the department. This includes agreeing on an appropriate scan time and turnaround time for the report depending on the clinical presentation of the patient. The duty radiologist and ward team are to communicate with the CT staff to aid with the prioritisation of incoming cases.

Going forward it has been agreed that the duty radiologist will alert the CT reporter to any urgent cases. The radiology level of urgency request protocol will now be included in medical teaching sessions and within simulation training.

Additional actions have also been agreed to support in the prevention of future issues. A bi-annual review of all of the requests will take place to identify if resilience has deteriorated over time and to highlight any changes; this will also ensure the process is still working as expected and identify whether the prioritisation of requests requires focus.

5) *Very poor standard of care in respect of continuity of care; leaving the vascular referral to Sunderland to a very junior doctor on-call who did not even know the patient;*

In addition to the ongoing education previously described the following actions have also been taken.

A review of the standard operating procedure for both internal and external handovers and the standard operating procedure for escalation are to take place by 31st June 2022. An internal audit will also be carried out looking at the referrals and transfers to specialist services to identify where service improvement is required. The audit is due to be completed by 1st July 2022.

The process of escalation is to be reinforced to ensure senior decision makers are aware of patients and their ongoing investigations and outstanding results to allow them to make recommendations on life threatening diagnoses. This action will be implemented and completed by 1st June 2022.

6) *An insufficiently robust review by The Trust of the circumstance leading to the death of Mr Alan Hodgson and of the lessons to be learnt from it, i.e. an insufficient review of the vascular pathway, including its dissemination, awareness and continuous training to improve the importance of the rapid escalation of care against the background of effective communications and handovers between staff to promote holistic patient care.*

Extensive work is ongoing to both increase the awareness of the vascular pathway and improve the training provided in relation to it across the Organisation. As described earlier in this response, and in further detail in the updated action plan (Appendix 1), learning in the form of patient story will be shared at all forums attended by clinicians and then going forward included in mandatory training sessions for all clinical staff. An e-learning module in relation specifically to the vascular pathway is being developed for staff to complete.

In addition to the internal policy review described under matter 5, an inter-organisational review is to take place with the regional Acute Trusts, tertiary units and the North East Ambulance Service (NEAS) within the Vascular Network, to look at the shared vascular pathway and how patients should be managed when a life and limb threatening emergency requires clinical surgical attention. A date is yet to be agreed with the Vascular Network however the target date has been set to 31st July 2022.

The Trust is working with NEAS, following the offer from them at the Inquest to provide inter-hospital ambulance booking training to the Trust, and logistics of this are being explored. The trust has requested a visual, single page 'quick reference' guide for clinical staff to support them in booking the correct transport. This will be provided to the Trust by NEAS on 31st May 2022 on receipt of the poster the Trust will be reproduce and provide all wards and departments by 30th June 2022.

I hope that you find the actions taken by the Trust adequate to address the issues that you have raised, but please do not hesitate to contact me if you require further information.

Yours sincerely

[redacted]
Executive Director of Nursing

[redacted]
Executive Medical Director

cc. [redacted], CEO
[redacted] Associate Director of Nursing, Patient Safety