NHS
Frimley Health
NHS Foundation Trust

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HM Assistant Coroner Jessica Russell-Mitra
HM Coroners Court
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11th May 2022

Dear Ms Russell-Mitra

I write in response to the Regulation 28 Report you issued on 7th March 2022, in relation to the inquest into the death of Mr Arthur Frederick Hall at Frimley Park Hospital, which concluded on 14th May 2021.

You will recall that the Trust wrote to you in July 2021 to reassure you that further actions to improve patient safety had been implemented in response to the concerns that you expressed during the inquest. I would like to take this opportunity to update you as to the situation in the Trust at present, and how we have responded to the concerns raised in the Regulation 28 Report.

Firstly, with regards to the information provided to patients following discharge from hospital, the Trust has significantly revised the post-colonoscopy discharge information given to patients, both following the initial incident and subsequent to the inquest into Mr Hall's sad death. This revised information clearly lists the concerning symptoms which may be indicative of bowel perforation, explicitly states that this is a medical emergency, and gives patients a number of points of contact where help is available. This discharge information underwent patient review in July 2021, with feedback demonstrating that the amount of information provided was clear and appropriate.

The Trust is committed to improving communication with its patients, and so teaching on how to effectively `safety-net` patients is a part of the mandatory induction programme for doctors working in the emergency department. The chief of service for the emergency department has been asked to consider how patients could be provided with written information post-discharge, although this is a complex issue due to the vast range of presentations seen there, and the varied information which would need to be provided.

With regards your concerns about the care provided to Mr Hall during his attendance at the Emergency Department on 1st February 2018, I would like to reiterate that as part of the Emergency Department Junior Doctors' teaching programme, a teaching session is provided on the management of common surgical presentations and post-procedural complications, including the management of abdominal pain post-colonoscopy. This mandatory teaching session is delivered in-person and via Microsoft Teams, every four months (most recently in February 2022), by a surgical consultant. As part of this session, it is made clear that abdominal

pain post-colonoscopy may be indicative of serious intra-abdominal pathology, and that surgical review and full investigation are mandated.

The Trust has also implemented extensive education around the limitations of erect chest x-rays in excluding intra-abdominal perforations, both by means of teaching sessions as described above, and `safety snippets` (important safety notices highlighting key learning points, which are displayed throughout the emergency department). Since the time of Mr Hall's death two of these safety snippets have been produced, to emphasise the limited role of chest x-rays in this circumstance, and that patients in whom perforation is considered a possibility, like Mr Hall, require a surgical review. These safety snippets remain on display within the emergency department.

Since the time of Mr Hall's presentation, the surgical and emergency departments have agreed that all patients presenting with potential post-procedural complications, such as abdominal pain post-colonoscopy, must have a surgical review. A snap-shot audit, performed in June 2021, confirmed that 100% of the doctors within the emergency department were aware of this policy.

In the Regulation 28 Report, concern is expressed that a second line of enquiry "an endoscopy or CTPA" (computerised tomography – pulmonary angiogram) were not undertaken. I am advised by my surgical colleagues that neither of these investigations are indicated in the investigation of an acute presentation of abdominal pain. Accepting the limitations of an erect chest x-ray, the next most appropriate imaging modality would usually be a CT scan of the abdomen and pelvis (CTAP), although as always, this, along with a decision about the degree of examination required, should be determined by the treating clinician taking into account the exact circumstances of each individual patient. However, as detailed above, the education and training provided to doctors in the emergency department is clear about the need for full investigation and the appropriate next steps if a diagnosis of intra-abdominal perforation is being considered.

The Regulation 28 Report details concerns that signs of sepsis were missed during Mr Hall's initial attendance to the emergency department. While Mr Hall had evidence of an *infection*, namely an elevated white blood cell count, he had no other defining features of *sepsis*, for example an elevated temperature, pulse rate, or respiratory rate. However, we would like to provide reassurance about the work that has and continues to take place across the Trust to improve the recognition and management of patients with sepsis.

In-line with recommendations from NHS England, the Trust uses a sepsis-screening tool and care bundle, based around the National Early Warning Score system. This screening tool will be incorporated into the forthcoming Epic computer system, due to go-live in June 2022, which will automatically highlight patients whose observations are consistent with sepsis and who require further investigation for this condition. The most recent audit of compliance with the sepsis bundle demonstrated almost 100% compliance for screening patients, and with the timely administration of antibiotics.

Training on the recognition and management of sepsis is part of the mandatory induction programmes for doctors, and the annual patient safety training for nursing staff and healthcare assistants. These training sessions are also incorporated into the continuing professional development programmes run for more experienced staff, for example on the surgical nurses

study day. In addition, in September 2021, to coincide with World Sepsis Day, the Trust ran a two-week sepsis `roadshow` providing further face-to-face training and to launch a new online training module.

The Trust has also recently appointed two sepsis fellows, partly to continue to develop training programmes around this key area, but also to allow more in-depth audit and quality improvement work to take place, as the Trust recognises that sepsis management is a continually evolving area.

As a result of these measures, the Trust can confirm that there have been no sepsis-related Serious Incidents in the past 2 years, and no other incidents relating to a failure to identify a bowel perforation following an endoscopic procedure.

The training programmes detailed above are on-going and will continue to evolve in response to the needs of staff and the healthcare system. The introduction of the Epic computer system represents a major investment in improving patient safety and will further improve the ability of clinicians to detect critically unwell patients and direct appropriate healthcare resource to treating them.

In summary, I would like to reassure you that the Trust has undertaken robust actions to address the concerns raised in the Regulation 28 report, in order to improve safety for its patients.

Yours sincerely

[redacted]

Medical Director
On behalf of the Chief Executive.