Great Western Hospitals NHS
NHS Foundation Trust

The Great Western Hospital
Marlborough Road
Swindon
SN3 6BB

[redacted]

9th May 2022

Private and Confidential
Christopher Morris
Her Majesty's Area Coroner for Manchester South
Manchester South Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

By email only: coroners.office@stockport.gov.uk

Dear Mr Morris

Re: Coroner's Regulation 28 Report into the death of Billy Longshaw

Thank you for your letter dated 16th March 2022, which included a Regulation 28 Prevention of Future Deaths Report, raising concerns about the circumstances which led to the death of Mr Billy Longshaw.

We take these reports extremely seriously and I am writing to share our response to your report, which aims to provide assurance that your concerns have been addressed and includes details of the actions taken or planned to reduce the risk of similar deaths.

Overview

Mr Longshaw was a 22-year-old man who was diagnosed with D2- Hydroxyglutaric aciduria (D2-HDA) with consequent learning difficulties. He presented to the Emergency department (ED) on 6th March 2022 accompanied by his father after travelling to this locality to visit a relative nearby. Mr Longshaw was unable to verbalise and so the history of the presenting complaint was established via his father. The presentation was of abdominal discomfort, nausea and vomiting and was relayed on presentation to ED at the Great Western Hospital at 23:36 hours. Initial observations documented at triage were not concerning and by the time of initial junior doctor review at 01:42 hours on 7th March Mr Longshaw was reported to be comfortable and was eating and drinking. Repeat observations identified a sinus tachycardia but there were no concerns raised on review.

Mr Longshaw was discussed with the senior ED clinician and the advice given was to perform a venous blood gas test to establish blood lactate levels. Abnormality of the blood lactate levels would have prompted further investigation. This was discussed with Mr Longshaw's father, but this option was not acted upon and Mr Longshaw and his father were allowed to leave ED with no further investigations.

Mr Longshaw then presented to Stepping Hill hospital and died despite attempts to resuscitate him. A post-mortem examination has determined the cause of death as

1(a) Acute Bowel Obstruction
1(b) Ischaemic Sigmoid Volvulus
2 Cardiomyopathy secondary to D2 – Hydroxyglutaric aciduria

The Trust was made aware of the death of Mr Longshaw on 12th April 2021 when the coroner informed our Legal Services Manager. A 48-hour report (a record of initial Divisional investigation) was presented to the Patient Experience and Review Forum (PERF) in July 2021, this meeting was attended by the Deputy Medical Director. The outcome of this review was that no further investigation was warranted on the basis of the information provided. We appreciate that the delay between receiving the information from the Coroner and the presentation of the investigation, may have meant that the report did not capture all the details and nuances of the event. We have since this time strengthened the oversight and communication between the corporate departments and the clinical divisions to ensure closer working, improved communication, and engagement.

Matters of concern and actions taken

"1) Notwithstanding Mr Longshaw died within 24 hours of being seen in the Emergency Department at Great Western Hospitals, Swindon, in circumstances where he was permitted to leave without basic blood tests being taken, any diagnosis being made, or serious abdominal pathology being fully excluded, it is a matter of concern that the Trust has not undertaken a detailed investigation into the care and treatment provided to him.

Prompt, rigorous and effective investigations into serious clinical incidents are essential to deriving learning and improving patient safety.

We currently have a programme for patient safety of which investigations are a key part. There is a process to determine which cases are investigated and to what extent. Our policy is based on the NHS Serious Incident Framework.

In January 2022 we reviewed our governance processes to enable more rigour in identifying incidents that warrant in depth investigation and to ensure more appropriate, in-depth exploration, challenge, and scrutiny of reports as a result we instigated a number of changes including,

- Reduced the number and format of reports presented at the meeting to allow more focus
- Stipulated that cases are presented by the report author, or a deputy with sufficient knowledge of the matter, to ensure opportunity to increase the exploration and examination of case details by involving the report author.
- Strengthened professional and speciality representation
- Ensures subject expert attend to provide appropriate expertise and challenge when required

As an action directly related to the concern raised, we have instigated an alert system to ensure that any incident that involves a patient who presents with a learning disability will have additional scrutiny

from our Learning Disability nurse and/or Safeguarding lead to ensure we have the appropriate professional oversight.

We are monitoring the effectiveness of the changes to our governance processes in relation to the management of all incidents since 2022 and will keep this under review.

2) The '48 Hour Report for Significant incidents resulting in Moderate Harm and above' prepared by an ED Consultant and others is fundamentally and obviously flawed (even when read against the Trust's own medical records), prefaced as it is by the assumption that 'the patient self-discharged against medical advice'. The Trust's (limited) review of this matter represents a missed opportunity to consider vital issues such as the presentation of patients with significant learning disabilities to the Emergency Department, and the practical application of the Mental Capacity Act 2005 in this clinical setting."

We have established Mental Capacity Act training in the Trust which is accessed by all staff in the Emergency Department, as a result of this case we have recognised the need to strengthen the education offering in relation to the Mental Capacity Act. An educational programme will commence in June called "Legal Literacy in the Emergency Department" this will cover a variety of areas including applying the principles of the Mental Capacity Act 2005 to the care of adult patients in the emergency department setting and the importance of documenting the rationales for action and decisions.

In the last 12 months we strengthened the self-discharge form to ensure application of the Mental Capacity Act 2005 is considered when a patient is considering to self-discharge against medical advice. We will be implementing a training and raising awareness programme in July to ensure widespread understanding and compliance across the Trust, following this we will audit the use and compliance of this documentation.

We have an established simulation training programme within the Trust which to date has had a primarily educational focus. We recognise the potential benefits of simulation as a tool for promoting and supporting Patient Safety. The simulation faculty have prepared a scenario based on the acute presentation of a patient with learning disabilities ensuring the following is covered

- specific needs of a patient with a learning disability
- application of the Mental Capacity Act 2005,
- consideration of diagnostic overshadowing,
- importance of senior review
- unknown component of when patient has complex, long term, and rare co-morbidities
- encourage professional curiosity to seek an established diagnosis

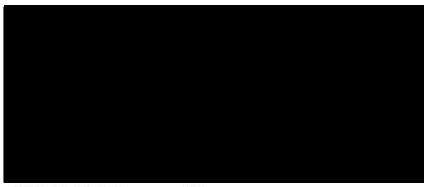
The above will be explored within this simulation and tools developed to support embedding the learning, filming is planned for early May. Once complete it will be uploaded to the Trust Learning Zone platform accessible to all members of staff, we recognise that although the index incident has occurred in the emergency department there is valuable learning in areas outside of this department. We plan to share the learning film and associated training materials across the system via the Patient Safety Network.

We recognise you raised a further matter of concern to the Chief Executive and Registrar of the General Medical Council relating to the provision and adequacy of education regarding the Mental Capacity Act 2205 to junior doctors, we would like to confirm our commitment to supporting the actions that the General Medical Council will take in relation to this matter.

I hope that this letter provides you with assurance that actions have been taken in response to address the concerns raised and reflect the focus of our continuing commitment to supporting the safety and care of patients admitted to Great Western Hospitals NHS Foundation Trust.

If you require any further information, please do not hesitate to contact me.

Yours sincerely



Chief Executive

Copy to: Care Quality Commission