To: **Ms Alison Mutch**
Manchester South Coroner's Court,
1 Mount Tabor Street,
Stockport,
SK1 3AG

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

[redacted]

8 September 2022

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – Vilem Bock who died on 6 June 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 28 April 2022 concerning the death of Vilem Bock on 6 June 2021. I would like to express my deep condolences to Vilem's family.

I note the inquest concluded that Vilem Bock died from the consequences of anticoagulation, given for one week between 18 and 25 May 2021, when there was a delay in a CT pulmonary angiogram (CTPA) scan being performed due to arrangements for an interpreter not being made at the time the CTPA was arranged.

Following the inquest, you raised concerns in your Report regarding whether, from a national perspective, there were protocols in place to ensure that other Trusts would avoid a similar situation arising where language was a barrier to accessing care.

Nationally, there is a protocol for Trusts to access translation services: Interpretation and Translation Services - NHS SBS. The Interpretation and Translation Services Framework Agreement provides a variety of translation and interpretation services. The services on this framework agreement include face to face (spoken language), British sign language (BSL), telephone interpretation and translation, document translation, plus video translation and interpretation. NHS staff are able to contact the service to secure interpretation services.

The Tameside and Glossop Integrated Care Foundation Trust (TGICFT) have also shared the following information with the Clinical Commissioning Group that commissions the services:

The following actions have been taken by TGICFT in relation to the provision of interpreters and translation services, and in disseminating the learning across the relevant teams in relation to the inquest:

- The TGICFT interpretation and translation policy was reviewed in regard to the systems and processes used for booking interpreters, to ascertain if this was a potentially contributory factor.

- Currently the Trust has a contract with DA Languages to provide interpretation and translation services. This includes the provision of face to face interpreting, telephone interpreting and the use of video interpreting. As part of the contract, ongoing conversations are taking place to see how additional mobile applications can be used to access interpreters in unplanned situations.
- A 7-minute briefing of the learning from local investigations and the inquest was completed, and this has been shared with the relevant staff. The importance of documentation reiterated through the sharing of this briefing was also directly discussed with staff, and this was led by a senior clinical lead.
- The investigation outcome will be shared as part of the Clinical Support Services Quality and Safety Meeting for awareness and learning, to help identify any similar instances or themes that need responding to.
- Reflective discussions have been held with the staff involved from the Booking and Scheduling Team within Radiology. Additional learning is also being shared Trust-wide regarding how to access interpreters.
- Interpretation services have been included in the Monthly Quality Assurance audits. Question 38 currently reads: 'Are Staff able to describe how they would access translator services?'. Additional information on how to access interpreters has been created to support staff awareness and learning.
- Specifically, within the Radiology Department, it has been agreed that the booking clerk will oversee any translator booking as part of their role and administrative duties. This responsibility to book interpreters is a requirement of ward staff.

An assurance review by the CCG in May 2022 has confirmed that all changes have been made. Future assurance reviews will be arranged to ensure that the changes have been embedded.

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. Trusts have been encouraged to review their systems and processes for interpreters to avoid a similar situation arising. This ensures that key learnings and insights around events, such as the sad death of Mr Bock, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director