The Queen Elizabeth
Hospital King's Lynn
NHS Foundation Trust

The Queen Elizabeth Hospital
Gayton Road
Kings Lynn
Norfolk
PE30 4ET

13 July 2022

Mrs J Lake
HM Senior Coroner for Norfolk
County Hall
Martineau Lane
Norwich
NR1 2DH

Dear Mrs Lake

Regulation 28 – in the matter of Mr Michael WYSOCKYJ (deceased)

Thank you for your report dated 24th May 2022 following the inquest into the death of Mr Michael Wysockyj. We set out our replies and action to the matters of concern you raised as follows:

1. The ED was busy at the time and unable to offload ambulances. An X-ray cannot be carried out on an ambulance and must wait until the patient is in ED. If the patient remains on the ambulance for several hours this can delay the X-ray taking place.

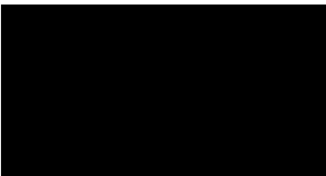
Response:
It is correct to say that an X-ray cannot undertaken on an ambulance because the radiology equipment that generates ionising radiation is insufficiently mobile and too large to be used in this setting. If it is thought by the assessing clinician who goes on to the ambulance that a patient's need for an X-ray is urgent or an emergency, that patient will be prioritised to be removed from the vehicle as soon as possible. Although conditions for patients are not ideal whilst waiting to enter the Emergency Department, in this way their clinical needs in terms of urgent imaging remain the same as if the patient had already been transferred into the department. The physical constraints mean that this problem cannot be overcome in any other way other than by carrying out a careful clinical assessment on arrival on the vehicle during busy periods outside the Emergency Department including obtaining the relevant history from the ambulance crew. This process is already well embedded.

2. The need for an X-ray remains with the nurse, nurse in charge and or doctor. If an X-ray is not carried out, the request remains with the nurse, nurse in charge and or doctor and it was not clear from the evidence that there is anything in place to ensure this is escalated and the X-ray takes place. This is something that can be missed in a busy department.

<u>Response:</u>
The Emergency Department does operate a system whereby two hourly rounds are conducted for patients in the department. This is carried out by the Band 7 nurse in charge and involves a checklist of clinical and other criteria to ensure that if clinically indicated, appropriate escalation takes place. The intention is that amongst all the other parameters if an investigation such as imaging or blood tests is awaited, these should also be escalated if there is a need to do so. However, it is correct to say that at the time of the inquest the check list contained no specific reference to investigations. The checklist has therefore been upgraded to include this (new version attached with the amendment highlighted). With this prompting, the Band 7 nurse in charge then goes back to the electronic ED record system (EDIS) because that already displays any outstanding investigations and whether they are overdue or have been carried out. There is a "red/green" system in place on a visible readout on the computer screen within EDIS whereby tests or radiology investigations which have not yet been completed can easily be identified by all clinicians. The Trust considers that this amendment to an existing process will be an additional safeguard to minimise the chances of the state of a patient's outstanding investigations being overlooked when there is high service demand in ED as well as the clinical support services they depend upon.

The Trust remains very committed to reducing clinical risk as far as possible and has a sophisticated incident management system. Nonetheless we are committed to taking on board comments and observations from external observers to support that process, including HM Coroner's office. We would be happy to assist further if any additional information is required.

Yours sincerely



Interim Medical Director