Greater Manchester Health and Social Care Partnership
4th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN

Date: 19 November 2020

Ms A Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Joan Margaret Sanderson 15.06.2020

Thank you for your Regulation 28 Report dated 5 October 2020 concerning the death of Joan Margaret Sanderson on 15 June 2020. Firstly, I would like to express my deep condolences to Joan Margaret Sanderson's family.

The inquest concluded that Joan Margaret Sanderson's death was a result of 1a) cardiopulmonary arrest; 1b) MRSA positive left hip metalwork infection; 2) Dementia, Diabetes mellitus.

Following the inquest you raised concerns in your Regulation 28 Report to NHS England regarding that there was no requirement for MRSA swabbing of patients being admitted for orthopaedic surgery, from a care home or those that have had a previous positive MRSA result. Whilst surgery would not have been delayed awaiting the outcome of results, it could impact the outcome in another case where emergency surgery is required and there is an infection post-operatively.

I have noted that your Regulation 28 letter has also been sent to HSIB and I will leave it to the named respondent to address the concerns which you have expressed. My letter therefore addresses the issues that fall within the remit of GMHSCP.

Summary of actions taken or being taken by the organisation involved.

The Trust confirmed that;

1. The MRSA Policy was updated in February 2019 to align with national screening guidance around MRSA screening of patients from other hospitals, nursing/residential homes, or those that have had a previous positive screen/clinical sample result on admission is undertaken.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Learning to be shared with the Greater Manchester commissioners of services to consider the findings of the investigation within the context of the services they commission

3. Learning to be shared with the Greater Manchester Infection Prevention and Control Collaborative for members to take into their provider organisations to ensure that national screening guidance is being followed. Findings to be also shared with the Northwest NHS England/Improvement Infection prevention for consideration of sharing across the Northwest

The Greater Manchester Health and Social Care Partnership (GMHSCP) is committed to improving outcomes for the population of Greater Manchester. In conclusion key learning points and recommendations will be monitored to ensure they are embedded within practice.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

Chair of GM Medical Executive, GMHSCP

27 November 2020

HEALTHCARE SAFETY INVESTIGATION BRANCH
HSIB, A1
Cody Technology Park
Farnborough
Hampshire
GU14 0LX

Alison Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch,

RE: Regulation 28: Report To Prevent Future Deaths. The death of Joan Margaret Sanderson on 15 June 2020

Thank you for contacting HSIB regarding a prevention of future deaths report regarding Joan Margaret Sanderson dated 5 October 2020.

Following careful consideration, we will not be taking forward an investigation into your concerns. We are only able to undertake a limited number of national investigations each year, and therefore try to focus on those with the most potential for new learning across the NHS. The National Criteria for selection is described on our website: https://www.hsib.org.uk/public-patients/how-we-decide-to-investigate/

We do not underestimate the seriousness of your concerns and may consider this issue again in the future as further information becomes available. The information that you have shared with us is important, even if we do not start an investigation as a result. Everything we receive is added to our database, whether we start an investigation or not. As it grows, our database builds a picture of risk in healthcare and allows us to identify recurring problems and patterns. Should we wish to contact you in the future regarding this information, it would help if we store the personal details you have given us, if this is acceptable to you. If you prefer that we do not keep your details, please let us know and we will ensure that they are removed from our database in accordance with our privacy notice (https://www.hsib.org.uk/privacy/).

Once again, thank you for contacting us and we are sorry that we are not able to take this forward.

Yours sincerely,

[redacted]
Chief Investigator