Office of the Chief Medical Officer

[redacted]

Deputy Chief Medical Officer:
[redacted]

Divisional Director:Surgery
[redacted]

Divisional Director:
Specialised Clinical Services
[redacted]

Divisional Director:
Emergency Medicine
[redacted]

Divisional Director:
Speciality Medicine
[redacted]

Divisional Director:
Women and Children
[redacted]

Worcestershire Acute Hospitals NHS Trust

Our Ref: CB/TW/2849

Date: 2nd August 2022

Miss E Brown
HM Area Coroner for Birmingham and Solihull

Via email only

Dear Madam

Re Regulation 28 Report to Prevent Future Deaths

I am writing to respond to your Regulation 28 Report to Prevent Future Deaths sent on 8 June 2022, following the Inquest touching the death of Jack Hurn.

In your Regulation 28 report you identified the following matters of concern

1. The Trust's internal review following Jack's death did not identify national and local guidance on the recognition and management of VITT that had been published at the time of Jack's admission to the Alexandra Hospital, or explore why the guidance was not followed.

2. Further, the internal review did not explore the concerns raised at the inquest about Jacks clinical care at the Alexandra hospital and in particular his deterioration during the afternoon of 9th June 2021.

I appreciate your concern that if our internal review processes are not sufficiently robust then learning will not be identified and appropriate actions implemented. I understand that you had already raised these concerns during the Inquest with [redacted] who had agreed to re-open the Trust's review and address the issues identified. This review started immediately that [redacted] had concluded his evidence and prior to receipt of your Regulation 28 report. I also confirm that the Trust has reinstated the serious incident record entry on StEIS (which is the NHS England system for reporting and monitoring of serious incidents across England) and the revised terms of reference for the investigation to include the issues that you have identified. The revised report is now being reviewed independently of the clinical division responsible for the care delivery, by my Deputy Chief Medical Officer, and will be shared with Jack's family and with our Integrated Care Board by 7th October.

I confirm that we have discussed the concerns raised with the Care Quality Commission and Clinical Commissioning Group (as was), in particular providing assurance about the actions taken in order that any future patients presenting at our sites are referred appropriately to tertiary services.

In terms of concerns about our initial report, we have reflected through our Serious Incident group, as to how the omissions occurred in the original review, which identified an overreliance on assurance obtained from internal expertise. The conclusion from the reflection was the importance of being conscious of the risks of bias influencing how an investigation is approached, rather than methodically carrying out all the steps outlined in our investigation process, which was not fully applied in this case. This would have included communication with the family to offer an opportunity to contribute, including identifying any concerns about care that they wanted to be incorporated in the terms of reference, and conducting an objective review of the medical records to highlight care or service delivery problems to further inform the scope of the investigation.

We are ensuring investigators undertake more comprehensive literature and independent evidence reviews when indicated, rather than relying on internal expertise, and ensure that the concerns of patient's family are sought and addressed in our reports. As part of our reflection we have recognised the need and actioned raising awareness of the Trust's Library Services who can support literature searches for existing clinical guidelines and publications, to our investigators.

You may also be aware that NHS England is due to publish their Patient Safety Incident Response Framework (PSIRF), which describes how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. Included as part of the framework are the National Standards for Patient Safety Investigation, published in 2020, designed to support improvement in the quality of patient safety investigation in NHS-funded care and specifies the basic requirements of reviews. The Trust completed a gap analysis of these standards against current practice, which is being used to inform the development of a revised investigation processes and report template as well as guidance for investigators. The Framework supports the National Patient Safety Strategy, to improve understanding of safety by drawing insights from patient safety incidents. To organise for successful implementation, the Trust restructured its central patient safety team in April 2021 to begin alignment of activities with the National Patient Safety Strategy. Plans for further alignment of activity to the national patient safety strategy, the framework and investigation standards continue to be discussed, to ensure we are able to reinforce our existing processes and apply them to ensure that learning is consistently identified and embedded to improve patient safety.

I hope that the above addresses your concerns about the quality of our initial review, which did not identify either the family concerns about a deterioration on the afternoon of 9 June 2021, or the existence of national guidance and a regional VITT pathway.

I have no representations in respect of publication of your Regulation 28 or this response by the Chief Coroner.

I shall be grateful if you could kindly send a copy of my response to anyone to whom copied your Regulation 28 report.

Yours sincerely,

[redacted]