Nottingham University Hospitals NHS Trust

Please ask for the Medical Director's Personal Assistant

[redacted]

8 December 2022

Medical Director's Office
3rd Floor, Trust Headquarters
City Hospital Campus
Hucknall Road
Nottingham
NG5 1PB

[redacted]

STRICTLY CONFIDENTIAL
Mr Gordon Clow
HM Assistant Coroner for Nottingham City and Nottinghamshire
HM Coroner's Court
The Council House
Market Square
Nottingham NG1 2DT

Dear Mr Clow

Inquest: Carl Wright - Prevention of Future Death Report [PFDR] Response

Please find attached a commentary in response to the Prevention of Future Deaths Report issued to Nottingham University Hospitals NHS Trust following the inquest into the death of Mr Wright.

My response to the concerns identified in the PFD report have been informed following work undertaken by colleagues within the Neurology Service, Surgical Division and more broadly in regard to medical management at the City Campus of NUH.

The actions either taken or planned in response to the learning from the inquest are summarised below. The oversight of the delivery of these actions will be through our Quality and Safety Governance Committees, with Executive oversight. Sub-Committees of our Boards will receive a progress report.

I hope that this commentary provides assurance that we are committed to learning from this, and other incidents to significantly enhance the care of patients across the Trust.

Yours sincerely

[redacted]

[redacted]
Medical Director [NUH]
[redacted]

Enc

[redacted]

Concerns identified through the PFDR

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows.

(1) The majority of medical care, including the identification and assessment of deteriorating patients, was done by inexperienced junior doctors with no easy access to input from more experienced doctors; and

(2) There was an established culture and practice of most blood tests results not being reviewed in a timely manner.

Other areas of concern existed regarding other issues but plans were in place to address these areas and so I did not have ongoing concerns of a risk of future deaths.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 December 2022. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting the timetable for action. Otherwise you must explain why no action is proposed.

Response to the concerns identified through the PFDR

Immediate Actions Taken

The Deputy Medical Director for Quality and Safety has met with the service to agree the below actions in response to the PFD.

Access to input from more experienced doctors

All patients who are planned to be transferred from an NUH in patient bed into Linden Lodge are now required to be physically assessed and reviewed by a Consultant from Linden Lodge, prior to transfer. This is to ensure that the patient is medically stable and suitable for transfer and for care within the Neuro-Rehabilitation Unit. The team are developing induction guidelines for junior doctors working in Linden Lodge, supported by an escalation process where a patient may be at risk of clinical deterioration [completion date 31/12/2022].

A Standard Operating Procedure [SOP] has previously been developed which outlines which medical speciality should be referred/escalated to at the City campus based on the presenting condition. For example, if postoperatively a City-based patient has signs of post-operative pneumonia the guidance means the responsible surgical team contacts the Speciality Registrar [SPR] for advice which in this scenario would be from the respiratory team, with the patient remaining under the care of the surgical team unless the respiratory team formally transfer the patient under their care. There are a small group of patients who do not clearly “fit” into this process, for example, presentations such as sepsis of unknown origin. For such patients the previous agreed process is that the on-call medical SPR would review the patient and seek telephone advice from the on-call medical consultant at the QMC campus and in rare circumstances transfer the patient to the QMC campus for ongoing management. The back up to this process is to contact the on-call consultant intensivist at the City campus Intensive Care Unit.

Review of blood test results in a timely manner

A SOP has been developed such that the review of all requested tests for patients are reviewed on a daily basis, supported by good documentation practice in the medical notes. This process has been built into the weekly ward round. Contingencies are in place if the weekly ward round is delayed or does not go ahead.

Summary

The actions set out above are intended to address the matters of concern identified in the Prevention of Future Deaths report in relation to ensuring that the medical care provided in Linden Lodge is delivered by appropriate experienced doctors supported by access to more experienced staff including the care of the deteriorating patient and the timely review of blood test results.

I hope this response provides both you and the family of our commitment to learning from this case to significantly enhance the care of our patients.