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Barking, Havering and Redbridge
University Hospitals
NHS Trust

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HM Senior Coroner
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Legal Services
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03 January 2023

Dear Sir,

Regulation 28 Report on the death of Peter Ross-Trust's Response

Thank you for your Regulation 28 Report of 04 November 2022. In your Regulation 28 Report to Prevent Future Deaths dated 04 November 2022, you set out the following matters of concern:

1) A CT C-Spine requested on 08 July 2020 requested on the admission was mis- reported as normal.

2) Following that report, during the initial referral of Mr Ross to Neurosurgery, the reviewing surgeon noticed an abnormality in Mr Ross's cervical spine, made no note of his finding and did not escalate the finding to any other clinician.

3) Prior to burr- hole surgery, the Neurosurgical team did not review the CT C-Spine images.

4) Repeated failures in communication between Neurosurgical, Emergency Medicine, Nursing staff and Physiotherapists led to serious harm to Mr Ross.

5) Clinical records were poorly maintained, exacerbating the lapses in communication between those treating Mr Ross.

In the opinion of HM Senior Coroner, action should be taken to prevent future deaths and he believes the Trust has the power to take such action.

Trust's Response

The Trust has carefully considered the concerns raised by HM Senior Coroner in his Regulation 28 Report and guidance has been sought from various specialists within the Trust as to the concerns raised by the Learned Coroner in his Regulation 28 Report.

The Trust's response to the concerns is as follows;

1) The Trust fully accepts that the CT C- Spine requested on 08 July 2020 was mis- reported as normal. The Radiology Department has completed all the actions assigned to the department within the Trust's SI recommendations and subsequent Action Plan. If any scan is mis- reported, the Department uses it as a learning opportunity, and it is reviewed at the Departmental Radiology Event and Learning Meeting (REALM) and undertakes a process of peer review. The Radiology Department has reviewed Mr Ross's scans through its Governance process.

2) All Neurosurgical trainees have training in Advanced Trauma Life Support 'ATLS'. All substantive Consultants need Level IV competence in dealing with neuro-trauma. They are aware that appropriate precautions must be taken for protection of the neck for a head-injured patient. All doctors involved in trauma care will be supervised by Consultants with ATLS competence. Patients are systematically assessed. This involves taking a history, examining the patient, arranging and reviewing all appropriate investigations, and formulating a management plan. Departmental policy is that all patients referred to the Neurosurgery department have a named Responsible Consultant. The Consultant on call works with and supervises the rest of the on- call medical team. All admissions, operations, and treatment limiting decisions must involve the Consultant on call. In this case, the reviewing surgeon who received the referral for Mr Ross did look at the scans and did inform the Consultant of his concerns. The Consultant on call was therefore aware and made decisions on management.

   The neurosurgery department has reflected on this finding and will be providing training to all non-consultant grade clinical staff in authoritative reporting as well as support with techniques regarding empowerment and escalation to ensure that any future concerns are raised to the appropriate responsible consultant. This training will focus on resilience, good communication and empowerment to speak out or challenge areas of potential failings. The department will closely monitor training outcomes for success (at LFG and M&M meetings) and will implement formal training as part of local induction for new doctors.

3) The clerking (initial neurosurgical assessment upon admission) should have included C-spine assessment and the ATLS approach should have been followed. Spinal precautions should have been re- instated. The Neurosurgery Department has sent a reminder to all staff in Neurosurgery regarding the need to consider C-spine injury in a head- injured patient. The matter has also been discussed at the Departmental Clinical Governance meeting. The Neurosurgery Department intends to include a section on trauma and ATLS within its induction process. Mr Ross's case will also be presented at the Patient Safety Summit.

4) The department has reflected on this finding and is developing better communication methods with all stakeholders and colleagues. This includes inviting clinical colleagues to local M&M, MDT and Clinical Governance meetings to discuss cases that include multiple disciplines for learning and agreed action planning. MDT's are now in a hybrid format which incorporates virtual and face to face meetings offering flexibility for a wider range of stakeholder attendance.

5) The department recognise there were failures in the standard of medical record keeping for this case. The neurosurgical specialty has taken this very seriously and will undertake documentation audit on the trauma neurosurgical pathway. Routine refresher training will be made available as well as training during local induction for new staff. This includes

orientation of our records system. The Trust is currently in the process of implementing electronic patient record system. The purpose of the new system is to provide clinicians with an easier to access tool to aid good communication, decision making and clear patient planning.

I would be happy to meet to discuss this response if that would be helpful to the Coroner.

Yours sincerely,

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Chief Executive