Department of Health & Social Care

From Maria Caulfield
Minister of State for Mental Health and Women's Health Strategy

39 Victoria Street
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[redacted]

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Mr Graeme Irvine
East London Coroners
Queens Road Walthamstow
E17 8QP

13 May 2024

Dear Mr Irvine,

Thank you for your Regulation 28 report to prevent future deaths dated 4 November 2022 about the death of Peter Mantador Ross**.** I am replying as Minister with responsibility for patient safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Peter Ross' death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the significant delay in responding to this matter.

The report raises concerns relating to: -

- The misreading of a CT C-spine on 8th July 2020
- Following that report, during the initial referral of Mr Ross to neurosurgery, the reviewing surgeon noticed an abnormality in Mr Ross' CT, made no note of the finding and did not escalate to another clinician.
- Repeated communication failures between; neurological, emergency medicine. nursing staff and physiotherapist led to serious harm to Mr Ross.
- Clinical records were poorly maintained, exacerbating the lapse in communication between those treating Mr Ross

In October 2020 Barking, Havering & Redbridge NHS Trust (the Trust) conducted a serious incident report to look into concerns surrounding the death of Mr Ross. This report found a number of lessons could be learned; these include:

- All neck clearance should be adequately documented within the notes. A normal CT scan alone is not adequate for clearance of spinal injury and removal of spinal immobilisation.
- Advanced trauma life support documentation should be completed for all trauma calls and should include clear documentation of how C spine has been "Cleared".
- As a good practice Neurosurgery teams should review all relevant CT images before surgery.

- Any suspicion of spinal injury even after initial assessment should prompt reinstatement of spinal immobilisation until the spine has been cleared by further imaging.
- Delay in appropriate spinal imaging may lead to potentially catastrophic harm to patients with suspected spinal injury.

In preparing this response, Departmental officials have made enquiries with the Care Quality Commission (CQC). CQC have engaged with the Trust and have discussed the specific areas of concern you have raised.

The Trust has provided assurance to CQC that this specific incident relating to Mr Ross was presented at the Trust-wide Patient Safety Summit. Proposed teaching sessions for staff were delivered, improvements were made to documentation, and implementation of these improvements were audited.

As part of CQC's regular engagement, CQC discussed with the Trust how they maintain oversight of implemented actions following the concerns you raised in your report, and how they ensure that learning about, and improvements to, safety and quality are sustained. The Trust stated to CQC they were in the process of reviewing these improvements, influenced by the introduction of Patient Safety Incident Response Framework and because they were making some staffing changes within clinical governance.

The CQC will continue to engage with the Trust and part of the focus of this engagement will be the review of the improvements the Trust has made.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Best Wishes,

MARIA CAULFIELD