Manchester University
NHS Foundation Trust

Joint Group Executive Medical Directors' Office
Trust Headquarters
Room 218, Cobbett House
Oxford Road
M13 9WL

[redacted]

11 July 2023

Mr C Morris
Area Coroner Manchester South
HM Coroner's Office
The Coroner's Court
1 Mount Tabor
Stockport
SK1 3AG

[redacted]

Dear Mr Morris

Mr Benedict Peters, Paragraph 7, Schedule 5 of the Coroners' and Justice Act 2009 and Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013

Thank you for your PFD report dated 16 May 2023, addressed to [redacted] in his capacity as the Group Chief Executive, Manchester University NHS Foundation Trust (the 'Trust'), which has been passed to me for review on his behalf.

I have now had the opportunity to look into the concerns you raise in respect of this case. Manchester Royal Infirmary (MRI) acknowledge the matters of concern that were raised within your report of 16 May 2023, and which emerged during the inquest for Mr Peters.

On behalf of the Trust, I would like to extend my condolences to the family of Mr Peters for their very great loss.

As the inquest heard; Mr Peters presented to the Emergency Department (ED) at MRI on 11 November 2022 at 09.00am with chest pain, shortness of breath, a sore throat and an aching arm. In the ED, an ECG was undertaken which showed normal sinus rhythm and his other recorded observations were essentially normal.

Whilst awaiting review, Mr Peters experienced a severe episode of vomiting. Blood tests were taken, and the prothrombin time was noted to be marginally elevated. Troponin and d-dimer levels were within normal limits.

Mr Peters was reviewed on the Ambulatory Care Unit (ACU) by a Physician Associate (PA). A chest x-ray was performed which was reported as being normal and following discussion with the duty consultant, Mr Peters was discharged with a diagnosis of panic attack/gastric inflammation and a prescription of propranolol and omeprazole.

Mr Peters was found to have died the following day, at his parent's home, having been staying there following his discharge from the MRI the day before.

Subsequent autopsy indicated Mr Peters had died as a result of acute aortic dissection.

Following receipt of your concerns, I have received assurances from Professor [redacted], Consultant Physician and Associate Medical Director for Clinical Governance in the MRI that this is an extremely rare condition and that none of the investigations performed on Mr Peters during

his attendance at the MRI ED revealed any suggestion of aortic dissection or rupture. Professor [redacted] informs me that Mr Peters' management has subsequently been reviewed by several different consultants from emergency medicine, acute medicine and cardiology, all of whom agreed that there was no indication in the mode of Mr Peters' presentation or investigation results to indicate such a diagnosis. Moreover, they were all in agreement that they would have adopted the same approach to management had they been caring for him.

Turning to your specific concerns:

1) *"Despite the patient's reported symptoms, in view of his age and extensive family history of cardiac problems, Mr Peters was discharged from the Ambulatory Care Unit without being examined/reviewed in person by a doctor"*

   Whilst I accept that Mr Peters was discharged without being examined or reviewed in person by a doctor (other than the junior doctor in ED who undertook his ECG), this does not mean that his case had not been properly reviewed and considered by a consultant.

   Mr Peters had been seen and assessed by a Physician Associate (PA), these are professional practitioners working under the aegis of the Royal College of Physicians of London which has produced guidance regarding their responsibilities and scope of practice (https://www.rcplondon.ac.uk/news/faculty-physician-associates). Within Manchester University NHS Foundation Trust (MFT), PAs work within an agreed governance framework (enclosed). This makes it clear that PAs are not independent practitioners (paragraph 12.7) but work under the delegated authority of a consultant (paragraph 14.2). It is the responsibility of the supervising consultant to ensure that the level of supervision is appropriate to the knowledge and skills of each individual PA. However, as they are not independent practitioners, PAs are not authorised to prescribe medication, order ionising radiation investigations nor discharge on their own initiative, which was not the case in this instance.

   In Mr Peters' case, the PA discussed the clinical picture with [redacted], Consultant Physician in Acute Medicine, who agreed with the diagnosis and plan formulated by the PA and went on to prescribe the discharge medication himself. In doing this, [redacted] was acting in the same way as he would had the case been presented to him by a junior doctor or nurse clinician seeking approval for their diagnosis and management plan, however; in these latter instances it would have been the practitioner themselves who would have prescribed the discharge medication. In all these circumstances it is the professional responsibility of the supervising consultant (in this case [redacted]) to ensure that they have confidence in the information provided by the practitioner (be they doctor, nurse or PA) and to seek any additional information they require directly from the patient should they believe it necessary before reaching a clinical decision.

   I would like to reassure you that although [redacted] did not review Mr Peters in person, he did review the detailed information provided by the PA as a result of which he had sufficient confidence to confirm the diagnosis and management plan; following which he also had sufficient confidence to issue a discharge prescription.

2) *"No policy or protocol exists within the Trust as to when patients may or may not be discharged from the Ambulatory Care Unit without a medical review taking place"*

   As you will have noted from the response above, it is policy within MFT that patients should only be discharged by appropriately qualified and registered practitioners. As PAs are not independent practitioners, they all understand that they are not permitted to discharge patients on their own authority and need to discuss any potential discharge decision and seek medical authorisation. Accordingly, there is no circumstance where a patient might be discharged from the Ambulatory Care Unit by anyone other than an independent practitioner without medical review of the case ('medical review' including discussion of the clinical picture and investigation results with a senior colleague).

The Trust remains wholly committed to providing safe and effective care to all patients delivered in accordance with national guidance. I hope that my replies above provide you with appropriate assurance that this guidance was indeed followed in the care given to Mr Peters.

We will remind all our PAs of the need to discuss patients for discharge with senior medical colleagues and reiterate to all junior medical staff and non-medical clinical practitioners, that it remains good practice to discuss cases with their seniors for learning and development.

If you require anything further, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Joint Group Executive Medical Director / Responsible Officer
[redacted]

Encl. MFT Physician Associate Governance Framework