University Hospitals Birmingham
NHS Foundation Trust

Trust Headquarters
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[redacted]

15 August 2023

For the attention of Louise Hunt
Senior Coroner for Birmingham and Solihull
Birmingham Coroner's Court
50 Newton Street
Birmingham

[redacted]

Dear Mrs Hunt

Inquest touching the death of Hilary Thomas

Response to Regulation 28 Report to prevent future deaths

I write in response to the Regulation 28 Report made by you following the Inquest touching the death of Mrs Thomas which concluded on 26 June 2023

University Hospitals Birmingham NHS Foundation Trust (the Trust) has carefully considered the concerns raised within your report to prevent future deaths relating to three matters of concern:

Department of Health and Social care

1. *Witnesses explained at the inquest that the volume of patients attending hospital is at a level the like of which has never been seen and current resources are unable to deal with that volume. This had a direct impact on Mrs Thomas's death as the doctor treating her was unable to review her blood tests results until the evening handover, 6 and a half hours after the results were available by which time Mrs Thomas had left the department.*

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2. *Mrs Thomas re-attended hospital with severe pain, was over age 70 and an unscheduled return within 72 hours. The Doctor should have considered and followed national guidance from the Royal College of Emergency medicine published in June 2016 (consultant sign off) which confirmed Mrs Thomas should have been reviewed by a consultant. Mrs Thomas was not escalated for consultant review. There was no evidence at the inquest that this guidance has been adopted by the Trust nor that staff are aware of it and have been trained on it.*
3. *The doctor treating Mrs Thomas on her second attendance decided to wait for blood test result before ordering a CT scan under the misunderstanding that these were required to assess the possibility of renal toxicity from dye used during the scan. The inquest heard evidence that a CT scan should have been undertaken and there was no need to wait for blood test results. This raised a concern that staff at the Trust are unaware of this guidance.*

[redacted]

1. Volume of patients presenting to the Emergency Department

This area of concern is for the Department of Health and Social Care however we acknowledge that there has been a significant increase in demand for assessment by the Emergency General Surgery (EGS) Service at UHB. This was the service to which Mrs Thomas was appropriately referred by the Emergency Department. In this case failure of assessment and escalation occurred after this referral. She was seen by the EGS service at 11:30am by an experienced Specialist Registrar (SpR) who was in the 7th Year of specialist training (ST7). When that SpR returned at 20:00 Mrs Thomas, after waiting for so long, had taken her own discharge. We acknowledge that Mrs Thomas had to wait far too long and that this was a failure of the EGS service. It has not been possible to establish why Mrs Thomas was not escalated to a consultant at the time of her presentation, or after it was found that she had self-discharged. It is the case that the service has been increasingly busy following the resolution of the pandemic. Although it is not possible to directly link the level of demand on this day to individual decision making, a response to increasing demand for surgical review is a matter which UHB recognises as a risk and to which the trust is responding.

These responses include:

- Provision of two dedicated consultants to manage the emergency surgical patients on the Birmingham Heartlands and Queen Elizabeth sites. These two consultants are freed from any elective activity when on call.

- The appointment of specialised Emergency General and Trauma Surgeons at the Queen Elizabeth Site.

- The creation of a virtual ward, managed by new specialist nurses, so that emergency patients can be managed on an ambulatory basis. This has saved over 1000 bed days this year and reduced the workload for the junior doctors on the QE site. This will be expanded to the Trust's other acute sites by 31 October 2023.

- Expansion of the EGS service by another two consultants by the end of 2023. This expansion will support the initiation of so called 'Hot clinics' for the expedited review of ambulatory patients. This will allow patients to bypass the Surgical Admissions Unit (SAU) and thereby reducing the load on junior doctors working in that area and the Emergency Department. It will lead to improved patient experience and reduce the number of patients in ED and SAU, allowing those units to focus on caring for the more unwell patients.

2. Risk stratification

In June 2016, the Royal College of Emergency Medicine (RCEM) identified high-risk groups of patients who should be reviewed by a consultant in Emergency Medicine before they are discharged from the Emergency Department.

The patient groups were:

i. Atraumatic chest pain in patients aged 30 years and over;

ii. Fever in children under 1 year of age;

iii. Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge; and,

iv. Abdominal pain in patients aged 70 years and over.

Mrs Thomas clearly fell into both category iii and iv so should have been reviewed by a consultant. In this case Mrs Thomas had been appropriately referred to the on call General Surgery team. It was therefore incumbent on the General Surgery team to make an appropriate assessment and formulate a diagnostic and treatment plan which would have included consultant review. This was not done. If Mrs Thomas's CT scan had been carried out immediately then she would have been admitted to SAU and subsequently reviewed by the EGS consultant on the ward round later that day. In this case, Mrs Thomas had to wait an unacceptably long time for repeat review, she therefore self-discharged and therefore without consultant review. The lack of consultant review was an effect of the delay in her being identified as requiring consultant review by the SpR at the time of assessment and later in the day. This is a single point of failure which, as previously mentioned, may have been exacerbated by workload.

The lack of consultant review will be mitigated by the increased provision for the EGS services which will reduce the workload on the junior doctors but this case also identifies a deficiency in policy.

On the second presentation it should have been clear that Mrs Thomas required admission and while this may always have been the intention of the assessing surgical SpR, this decision was delayed waiting for blood results and a CT scan. This is the aforementioned single point of failure.

The Trust has therefore implemented a new policy developed by the Clinical Service Leads for EGS and ED, alongside a programme of education (from August 2023) in which any member of the multi-professional team are invited to escalate concerns regarding delayed assessment, or delayed transfer of patients to SAU, to the consultant on call. This will be enhanced by a communication strategy that will include direct teaching and laminated posters displayed in acute surgical areas at all acute sites (by 31 October 2023). This communication will emphasise the importance of this action for patient safety and will not be a punitive action.

In this case where Mrs Thomas had not been "accepted" by EGS, any ED healthcare professional would be empowered to escalate this to the EGS consultant.

3. **Emergency CT scans and the use of Intravenous Iodinated Contrast Agents**

Computed Tomography (CT) scanning is an important diagnostic modality in patients with acute abdominal pain and the use of intravenous iodinated contrast agents

significantly enhances the diagnostic accuracy of CT scans. For many years, knowledge of functional renal status (as documented by blood test results) has been required prior to giving iodinated contrast agents.

Modern contrast agents are much safer than older agents and studies have reported that blood tests are not required for emergency CT scans. In June 2023, the Royal Colleges of Radiologists & Royal College Emergency Medicine published joint guidance, strengthening previous guidance, that patients requiring emergency iodinated intravenous contrast CT imaging should proceed to scanning without delay. The Trust will ensure that relevant staff are aware of this guidance and will ensure that it is disseminated to all staff managing acute surgical emergencies.

Following Mrs Thomas's death the following actions are being taken to share the learning from this incident:

1. **Locally:** Laminated posters of the joint statement will be displayed in acute surgical areas at all acute sites. A new trust policy that directly reflects the June 2023 guidelines will be published and disseminated to all clinical staff. The Trust will update online requesting system to reflect the new guidance. This will be discussed at all relevant departmental governance meetings. These actions will be completed by 31st October 2023.

2. **Regionally:** The Trust will engage with the West Midlands Postgraduate School of Surgery to ensure all General Surgical speciality trainees are informed of the updated guidance. It is anticipated that this will be within the induction programme and will be included in literature provided to junior doctors.

3. **Nationally:** The Trust will report this incident to the Confidential Reporting System in Surgery (CORESS).

I would like to reassure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously which I hope is demonstrated by our response above.

Yours sincerely

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[redacted]
Chief Medical Officer

CC: [redacted], Chief Nurse
[redacted] - Green, Chief Nurse and Deputy Chief Operating Officer, ICB
[redacted], Chief Medical Officer, ICB
[redacted], Head of Clinical Governance and Patient Safety