NHS
Nottingham
University Hospitals
NHS Trust

[redacted]

[redacted]

30 August 2023

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Dr Elizabeth Didcock
HM Assistant Coroner for Nottingham City and Nottinghamshire
HM Coroner's Court
The Council House
Market Square
Nottingham NG1 2DT

Dear Dr Didcock

Inquest: Gordon Renfrew - Prevention of Future Death Report [PFDR] Response

I am writing in my capacity as Medical Director of Nottingham University Hospitals NHS Trust in response to the Prevention of Future Death Notice issued on 6 July 2023 following the sad death of Mr Gordon Renfrew.

May I begin with offering my sincerest condolences to Mr Renfrew's family for their loss. I am deeply sorry for the missed opportunities and issues that were highlighted during the Inquest.

The concerns you have raised have been taken extremely seriously. 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 Gordon Renfrew.

My response to the concerns identified in the PFD report have been informed following work undertaken by colleagues within the Stroke, Neurosurgery and Interventional Radiology service.

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 - Committees of our Board 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]

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows – · There is limited evidence to date of improved communication, and a stronger working relationship, between the stroke team and the neurosurgical team at the Trust · There is limited evidence to date of the Stroke team having a clear understanding of the NICE guidance regarding Decompression Craniectomy, specifically the importance of detailed careful monitoring post stroke, with clarity about referral criteria to Neurosurgery. The planned Standard Operating Procedure, which may set out this clarity is not yet finalised. · There are currently limited opportunities for joint case discussion and learning between the Stroke and Neurosurgical teams. The Interventional Neuroradiologists could of course also usefully participate in such Educational opportunities – I note it was [REDACTED], (Consultant in Interventional Neuroradiology) rather than the Stroke team, who asked that Gordon was reviewed by the Neurosurgical team on the early evening of the 7th June 2022 I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you have 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 the **31st August 2023**. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

Response to the concerns identified through the PFDR

There is limited evidence to date of improved communication, and a stronger working relationship, between the stroke team and the neurosurgical team at the Trust

The Trust held a Joint PFD response meeting 7.8.23 chaired by [redacted]

MDT attendees included stroke, neurosurgical and mechanical thrombectomy (MT) operational and governance leads. Divisional representation included medical and nursing colleagues and members of the Patient Safety Team. The agenda focused on conducting a pathway review from point of referral to intervention and aftercare.

Following this meeting, key principles were agreed:

- On call stroke consultant to be informed and responsible for all admissions, including tertiary referrals made directly to the Mechanical Thrombectomy team.
- On call stroke team and Mechanical Thrombectomy team to be electronically informed of patient admissions.
- The Mechanical Thrombectomy team will be responsible for the patient during the procedure including confirmation of complete informed consent.
- Post procedure, the responsible stroke consultant is to provide ongoing care including monitoring and onward referral in the event of complications.
- In the event of the Mechanical Thrombectomy team considering a direct neurosurgical referral, the responsible stroke consultant will also be informed.
- The pathways will continue to be monitored at the monthly meeting of the Mechanical Thrombectomy Steering Group chaired by the Deputy Medical Director.

The Trust also held an Inter-speciality meeting on 24.7.2023 chaired by [redacted] (Head of Service Neurosurgery) and attended by stroke and neurosurgery heads of service, governance and pathway leads. (Document 1)

During this meeting the following issues were discussed;

- Affirmation of method of referral of stroke patients to Neurosurgery for decompressive craniectomy in relation to NICE criteria.
- Consensus on how to manage medical issues around stroke management, stroke care in neurosurgery/ITU.
- Stroke service will have oversight for local patients and those referred as part of tertiary service provision.
- Consensus on post-operative use of anti-platelet agents and enoxaparin. This included the evidence and risk benefit of starting venous thromboembolism (VTE) prophylaxis and use of aspirin.
- Early cranioplasty patient selection following craniectomy

There is limited evidence to date of the Stroke team having a clear understanding of the NICE guidance regarding Decompression Craniectomy, specifically the importance of detailed careful monitoring post stroke, with clarity about referral criteria to Neurosurgery. The planned Standard Operating Procedure which may set out this clarity is not yet finalised.

The NICE guidance has been re-emphasised with all teams across the pathway and is now incorporated into the SOP. This was discussed during the inter-speciality meeting on 24.7.2023. It was agreed that the NICE guidance is to be incorporated into the cross-departmental SOP. This has now been finalised and due for circulation and to take effect from 1.9.2023. (Document 2).
Patients undergoing Decompressive Hemicraniectomy will be monitored through stroke and neurosurgery governance pathways and will report to the Mechanical Thrombectomy Steering Group.

The Stroke Department also held a teaching session on Decompressive Hemicraniectomy for ischaemic stroke on 3.7.2023.

This session included indications, process of referral and post-procedure care. It was attended by consultants, trainees as well as advanced care practitioners.

The department have also introduced specific teaching at induction around decompressive surgery. Nursing teaching sessions have been organised with the stroke teaching practitioner. A presentation was also made to new registrars in early August and has been uploaded to the Trust's intranet. This includes details around decompressive surgery. (Document 3)

A simulated session (SIM session) on how to manage a malignant MCA stroke scenario for medical registrars was delivered on 24.8.2023 by one of the stroke consultants.

There are currently limited opportunities for joint discussion and learning between the Stroke and Neurosurgical teams. The Interventional Neuro-radiologists could of course also usefully participate in such Educational activities.

It was agreed at the joint PFD response meeting on 7.8.2023 to develop joint learning strategies between the Stroke, Neurosurgical and Neuro-Radiology teams.

In addition, all cases of decompressive surgery are to be presented and discussed at the quarterly regional stroke meeting with representatives from stroke and MT services throughout the region.

Cases involving both specialities will continue to be discussed at service M & M meetings and relevant colleagues from other specialities involved in the delivery of care will be invited to the meeting. Cross speciality attendance may not always be feasible but regardless, the minutes of individual speciality meetings are to be shared across specialties and actions should be discussed with governance and service leads. This is to be implemented across the Trust.

In cases that trigger a SJCR and pathways of care that cross specialties, services should co-ordinate their response through their governance leads and agree around actions, learning and duty of candour. This is to be implemented across the Trust.

Complex Mechanical Thrombectomy cases will continue to be presented at and discussed at the Mechanical Thrombectomy steering group with identified learning to be disseminated through Mechanical Thrombectomy pathway leads from radiology, stroke and neuro-interventionists.

Summary

The actions set out above are intended to address the matters of concern identified in the Prevention of Future Deaths report to ensure that there is a stronger working relationship between the stroke and neurosurgical teams. I hope this response provides both you and the family of Mr Renfrew our commitment to learning from this case to significantly enhance the care for our patients.