Hampshire Hospitals
NHS Foundation Trust

Basingstoke and North Hampshire Hospital
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[redacted]

Mr Robert Simpson
H.M. Assistant Coroner for Hampshire, Portsmouth and Southampton
Coroner's Office
Castle Hill
The Castle
Winchester
SO23 8UL
[redacted]

7 November 2023

Dear Sir

**Inquest in relation to the Death of Sebastian Harry Daniels**

I acknowledge receipt of the Prevention of Future Deaths Report dated 22 September 2023 (the "Report"), issued by the Assistant Coroner Mr Robert Simpson for Hampshire, Portsmouth and Southampton, to Hampshire Hospitals NHS Foundation Trust (the "Trust"), under paragraph 7, schedule 5, of the *Coroners and Justice Act 2009* and regulations 28 and 29 of the *Coroners (Investigations) Regulations 2013*.

Firstly, on behalf of the Trust, I offer my sincere condolences to the family of Mr Daniels, to whom I am very sorry for their loss.

I note that three concerns have been raised by the Assistant Coroner in the Report, the first and second of which require a response from the Trust and the third which is to be responded to by Southern Health NHS Foundation Trust. I set out below the concerns which relate to the Trust, together with our response.

1. **"The abnormal triglyceride levels in Mr Daniel's blood, whilst reported by the lab, were not escalated by telephone as this was not required by the hospital procedure at the time.**
   **I am pleased to note that Hampshire Hospitals Trust have updated their procedures to include telephone escalation of raised triglyceride levels.**
   **However the RCA report indicated that the findings in this case should be shared with the Royal College of Pathologists with a request that raised triglyceride levels be added to the RCPath guidelines for telephone action. In information received after the inquest the Hampshire Hospitals Trust advised that they could not tell me whether or not this action has been undertaken."**

Within the multiagency RCA investigation report this action was allocated to our colleagues at the Hampshire and Isle of Wight Integrated Care Board (ICB) and not to our Trust.

Prior to the inquest hearing and in order to assist the Court so far as possible, the Trust made contact with the ICB who confirmed to us that they had shared the findings of this case with the Royal College of Pathologists and requested that they consider adding raised triglycerides levels to their guidelines for telephone actions in critical results.

The Royal College confirmed to the ICB that they would share and discuss the recommendation with the Hematology Specialty Committee and the lead of the related Royal College guideline, as it was due to be reviewed in any event. Despite numerous attempts by the ICB, they have been unable to obtain any further update from the Royal College.

Unfortunately we are unable to comment any further on this point, as whether raised triglyceride levels are added to the Royal College guidelines for telephone action is a decision for the Royal College and not the Trust. We can, however confirm that the NHS, by way of the ICB, did share the findings with the Royal College and request that the guidelines were updated.

2. **"The RCA report identifed that the format of discharge summaries provided to GPs by the ED department needed to be reviewed to ensure that actions to be undertaken by GPs were clearly identified. The results of this were to be audited.**
   **Following the inquest I was provided with an audit report. This report dated 13/9/21 revealed that the computer system could not be altered as had been hoped and therefore a change of practice was introduced instead. This required clinicians to document actions in a free text section with appropriate flagging for GPs. 20 cases were audited and only half met the standardised national guidance and 8 lacked a clear diagnosis & details of what was expected from GPs.**
   **Hamsphire Hospital Trust have informed me that further actions are being taken to address these deficiencies. However as it is now a year since the RCA report was prepared and over 2 years since Mr Daniel's death I am concerned that this action is not being taken swiftly given the risks to patients."**

Following your direction at the inquest hearing, for an update on the action set by the multi-agency Root Cause Analysis (RCA) investigation undertaken following the death of Mr Daniels, the Trust carried out an audit dated 13 September 2023 which identified the requirement for further action to be undertaken by the Trust.

The Trust has commissioned a new computer system (Alcidion Miya Emergency) which is set to go live in July 2024. We are working with the developers to ensure that as a function of that system, ED clinicians will be prompted to automatically highlight to GP's any patients who have abnormal blood results.

As there will be several months until full implementation of the new system, the Trust has worked with the IT service to ensure that patients with abnormal blood results will now be allocated a different discharge code, which will then prompt the administration team to physically print the abnormal blood results and attach them to the discharge letter before sending it on to the GP. GPs have been notified of this change via the GP liaison service as per enclosed correspondence.

ED clinicians have also been notified that they are required to continue to document significant findings and matters requiring GP attention, under a separate heading within the GP free text notes box, on the Patient First discharge summary. It was felt that compliance of this, as documented within the audit, was likely limited due to the turnover of trainee doctors. In order to ensure that all staff remain aware of this requirement the Trust is in the process of updating its junior doctors induction program to include the above changes in the discharge process. This with take effect from the next induction taking place on 6 December 2023.

In order to monitor the impact of these actions the Trust will re-audit a random sample of discharge letters at three and six months.

I would also like to take this opportunity to confirm that the recent introduction of the Patient Safety Incident Response Framework (PSIRF), the Trusts approach to investigation of patient safety incidents has changed. Actions in response may now take different forms, ensuring that actions are completed as soon as practicable, with more rapid action undertaken to respond to immediate risk.

Developing safety actions in response to system issues identified in learning responses will be undertaken in a collaborative way. Safety actions will be written clearly and will follow SMART (specific, measurable, achievable, relevant, timebound) principles. A Trust-wide safety action log will be held with the aim of reducing duplication and disconnected safety actions.

The implementation of safety actions will be overseen by the Divisions, with reporting to the Safety Action Delivery Group. This is a sub-group of the Patient Safety Improvement Group. The Patient Safety Improvement Group will monitor the timeliness and effectiveness of action implementation. This group will also support work to align quality improvement and patient safety approaches.

I am confident that the combination of the changes will mitigate the risk of similar circumstances occurring in the future. Should there remain any further concerns, I would welcome the opportunity to address these for you.

Yours faithfully

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**Chief Executive**
**Hampshire Hospitals NHS Foundation Trust**