Anita Bhardwaj
Liverpool and the Wirral Coroner's Service
Gerard Majella Courthouse
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National Medical Director
NHS England
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13 February 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Katherine Sarah Flynn who died on 6 March 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 30 November 2023 concerning the death of Katherine Sarah Flynn on 6 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Katherine's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Katherine's care have been listened to and reflected upon.

Your Report raised the concern that there was no standard national policy dealing with how to escalate things when an external ventricular drain (EVD) stops draining but appears to still be oscillating.

While there is currently no NHS-wide national policy available regarding nursing care of patients with EVDs, local policies (examples of which are included in the footnote below[i]) and educational material regarding best practice are readily available. There is also national nursing guidance available from the British Association of Neuroscience Nurses regarding Cerebrospinal Fluid (CSF) Management. Leading Clinical Neurosurgery colleagues have also reviewed your Report and advised that every neurosurgical unit will have their own work skill mix and resources and be expected to develop locally relevant policies that would be valuable, relevant and safe. We note that in Katherine's case, local policy was unfortunately not followed.

Regarding educational material, nursing care of patients with EVD is discussed in Humphrey E (2018) Caring for neurosurgical patients with external ventricular drains. *Nursing Times* (online), 114 (4), pp.52-56. Humphrey (2018) refers to the importance of checking oscillation and dressing. In a separate paper, Bertuccio et al (2023) also notes blockage as the most common complication of an EVD. The National Institute for Health and Care Excellence (NICE) also launched a consultation document in February 2021 regarding an evidence review for managing hydrocephalus.

Considering your Report, NHS England's Patient Safety Team and Nursing Directorate have discussed how to address your concern about national guidance and the care delivered to Katherine and have established some next steps and recommendations, outlined below.

It is proposed that the Society of British Neurological Surgeons (SBNS) co-lead with NHS Nurse Specialists to develop an action plan and national guideline for EVD management. A short life Working Group (comprising both Surgeons and Specialist Nurses) should be considered as the way forward with input from NHS England's National Patient Safety Team. The Patient Safety Team plans to reach out to the SBNS, who we note that you also sent your Report to.

The Patient Safety Team will also be undertaking a search of reported incidents and undertake a thematic analysis regarding any EVD incidents over the last three years to identify any additional cases or emerging themes to inform future work. It is noted that, to the best of NHS England's knowledge, Katherine's case is the only one regarding EVD on the Courts and Tribunals Judiciary website: search for EVD - Courts and Tribunals Judiciary.

It is noted from the Report that the Registered Nurse involved in Katherine's care did escalate their concerns regarding oscillation prior to the dressing becoming wet. Further detail regarding this first escalation may clarify why they did not escalate a second time when the dressing became wet. Is the coroner able to provide any further information on this? This information may be relevant to identifying further actions to be included in the action plan referenced above.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]
National Medical Director

[i] Greater Glasgow and Clyde (2020), University Hospitals Bristol and Weston NHSFT (2022), The Walton Centre (2023), Great Ormond Street (2019)