



HMC Coroner's Office (Leicester City &
South Leicestershire)
Town Hall
Town Hall Square
Leicester
LE1 9BG



1 February 2024

Dear Madam

Re: Death of Mrs Lindy Aston

On behalf of the Trust I am writing further to the Prevention of Future Deaths report (Regulation 28) that we recently received in relation to the death of Mrs Aston, to provide you with an update on progress with the learning and actions that have taken place which address your concerns raised in the report.

We extend the Trust's condolences to Mrs Aston's family, following her sad death.

Surgical decision making

- 1) Possibility of lack of theatre capacity
- 2) Surgical decision making on the part of a single consultant

The Trust acknowledges that clear processes need to be in place to ensure emergency theatre capacity is available when needed to prevent this situation happening again. A Standard Operating Policy (SOP) is in place which addresses the steps to be taken when prioritisation of emergency operations needs to be considered. The SOP considers both obstetric and general surgical emergencies in main theatres and addresses the safe staffing of emergency theatres throughout the 24-hour period. The safe use of theatres is monitored and managed through daily theatre safety huddles, (additional huddles are agreed if required) which are documented, and any risks clearly identified and managed or escalated as needed. This SOP was put in place following Mrs Aston's sad death.

Whilst the responsibility for decision making regarding a patient's care rests with the named consultant, all members of the clinical team are encouraged to speak up if they have any safety concerns in real time. One such example is "Stop the Line" which was been introduced into the treatment centre in May 2023 and which has been rolled out



across the Trust in the last 8 weeks. This is now on Datix so is part of the patient safety incident form and reporting.

The purpose behind this is that if it does not feel right or if it does not look right, it might not be right, so speak up and speak out there and then. "Stop the Line" forms part of the 'who' checklist, which is used in the daily huddle meetings, this ensures that the members of the team know each other and empowers even the most junior person to be able to have their voice heard by the team.

The Trust has a well-developed Freedom to Speak Up process with an active Freedom to Speak Up Guardian and several specialty-based Freedom to Speak Up ambassadors. Freedom to Speak Up enables staff to report any concerns if they did not feel able to do so in the moment and can be done anonymously, whereas Stop the Line is aimed at empowering staff to speak up 'in the moment' if there are any concerns. The Trust does have safety and raising concerns as a central part of its culture work and will continue to review existing paths to reinforce raising concerns and challenging a decision.

It is also important to note that decisions to operate are made in consultation with a senior anaesthetist and inpatients who require higher levels of care, the Intensive Care Unit Consultant would also be involved in decision making. Where appropriate, advice from a tertiary centre can be sought to make care safer as part of a multidisciplinary approach.

Trust investigations into Mrs Aston's care

A concern was raised regarding the inadequacy of the investigation and incident reporting processes at Kettering General Hospital (KGH), which in turn has led to a delay in learning with the potential to negatively impact patient safety across the whole Trust.

We have reviewed the Trusts *Medical Examiner and Mortality Review and Learning from Adult Inpatient Deaths Policy (Ref GOV01)*. The policy is very clear in relation to the Structured Judgement Review (SJR) outcomes. Section 8 of this policy refers to the processes to be followed when the outcome of an SJR is deemed very poor or avoidable with a score of 1-3. More specifically, section 8.5 refers to the process to be followed when an SJR is referred from an external organisation, for example when a patient was treated at KGH, then transferred to another hospital, and dies. This section states that these referred concerns will go through an SJR process and governance process for mortality reviews.

A round table panel was convened 23/2/2022, following notification from the Coroner of Mrs Aston's death. The panel made the decision that no further action need be taken.

The process carried out did not follow Trust policy and consequently the policy section has been re-written to ensure absolute clarity of the process. The updated policy comes into effect from 1/2/24 and will read as follows:

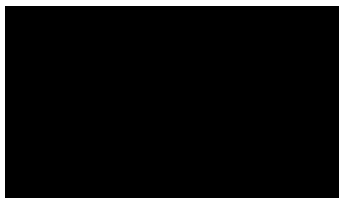
- *If a patient has recently attended / admitted to the Trust, and subsequently died where potential problems in health care are identified by any external care providers, the following process must be adhered to:*
- *Formal notification to the Mortality Review Team.*
- *Case to be logged / overview provided at one of the following committees to ensure timescales and any actions are formally monitored:*
 1. *Serious Incident Review Group (SIRG)*
 2. *Learning from Deaths Group (LFDG)*
 3. *Deteriorating Patient Steering Group (DPSG)*

- *KGH notes to be reviewed utilising Structured Judgement Review (SJR) methodology and where applicable, external care provider notes to be included within local review.*
- *Should any problems in health care (associated to care provided at Kettering General Hospital) be identified, this will be detailed in the Structured Judgement Review. Any case that meets the Structured Judgement Review escalation threshold will be discussed at a multi-disciplinary ad-hoc Mortality Review Group.*
- *Findings to be shared and approved with the Medical Director's Office before disclosing externally.*

A learning brief has been prepared and circulated to ensure consistency of messaging and understanding of responsibilities.

I hope you find assurance in this letter that the Trust's response to this tragic death has been robust and if you would like any further information, please do not hesitate to contact me.

Yours faithfully



Hospital CEO