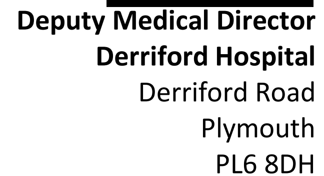


Deputy Medical Director
Derriford Hospital
Derriford Road
Plymouth
PL6 8DH

Date: 2nd February 2024

Private and Confidential

Dear Mr Davies,

I am writing in response to your recently issued Regulation 28 Report dated the 7th of December 2023 concerning the sad death of Mr Ian Jacka. On behalf of University Hospitals Plymouth NHS Trust, We would like to begin by offering our sincere condolences to Mr Jacka's family for their loss.

Thank you for highlighting the concerns regarding Mr Jacka's death, we apologise that you have had to bring these concerns to our attention. We understand the severity of your concerns and are committed to making the necessary improvements that ensures the quality and safety of our services and prevents harm to future patients. A full investigation into each of your concerns has been undertaken and I have documented our response below. I hope that this response will satisfy you that we have robust processes in place and have taken the necessary action required to prevent a future death.

- ***There was an error of omission in record keeping and in handover from critical care to surgery, and that this error likely contributed to Ian's death.***

- ***There was no entry in Ian's hospital notes to indicate the full extent of the critical incident of 5 June 2022.***

- ***There was a lack of information on handover from critical care to the surgical team regarding the full extent of the critical incident of the 5 June 2022. There was a verbal handover which was brief and vague. There was no formal written handover process highlighting significant events.***

- ***The error of omission was unexplained and has not been investigated by the NHS. The evidence regarding the error of omission came to light after the completion of the NHS investigation into Ian's death. The Consultant Anaesthetist involved in Ian's operation discovered the fact of the critical incident of 5 June 2022 on a later examination of ventilator data. The data indicated that Ian deteriorated significantly, that he was close to a cardiac arrest and the critical care team saved his life.***

We have undertaken a full review of the record keeping and handover arrangements relating to this Mr Jacka's care. A review of Mr Jacka's clinical records demonstrated that the event that occurred in

the early hours of the 5th June 2022 was documented following the event at 04:24 in the intensive care Electronic Patient Record System (Innovian) by the medical team.

The documentation in relation to the critical incident is both comprehensive and appropriate. Mr Jacka deteriorated, requiring intubation and ventilation as a result of type 2 respiratory failure caused by his significant chest and spinal injuries. His blood oxygen saturations and blood pressure fell significantly but were rapidly restored to normal upon the arrival of the ICU registrar with simple interventions after a relatively short period of time. The lowest oxygen saturations and blood pressure values were recorded in the notes by the ICU nurse at the time. Mr Jacka was anaesthetised and intubated – this was technically challenging and represented a difficult airway, but Mr Jacka remained stable throughout this process with no further drop in oxygen levels. Following successful intubation, the Intensive Care Registrar documented a plan for ongoing sedation overnight, and for the Neurosurgeons to be informed. A plan for subsequent intubation was also documented which included appropriate recommendations for airway management; "*For further intubations: Awake fibreoptic if situation permits, or CMAC D + bouguie + collar off*".

The airway technique used and the difficulties encountered during the intubation were both documented in Mr Jacka's medical notes and verbalised to the anaesthetic team when they reviewed Mr Jacka pre-operatively on the 6th June 2022. The anaesthetic Pre-assessment Record completed by the Anesthetic Registrar pre-operatively documented the following in the 'Intubation hazards' section; "*emergency intubation – V difficult. Size 7 ETT. Grade 4. CMAC D blade – epiglottis only. Able to ventilate with FM and Guedel. Size 7.0 ETT*". This is consistent with the details documented within the intensive care Electronic Patient Record System following the event on the 5th June 2022 and demonstrates that there was not an omission in record keeping or handover.

Investigation into events performed after Mr Jacka's death did not identify missing information from the clinical record, or evidence that his deterioration was more significant than that documented in the contemporaneous record.

- ***The surgical and anaesthetic team had no reason to suspect a secondary brain injury. The team had no information on Ian's neurological status. Ian is likely to have suffered a hypoxic brain injury during the critical incident of 5th June. This will have undermined his resilience and ability to physically withstand the rigors of spinal surgery and airway exchange.***

A review of Mr Jacka's clinical records identified that the Neurosurgical team reviewed him on the 5th June 2022 at 09:00 and Mr Jacka's deterioration and the need for intubation and ventilation was acknowledged. The Neurosurgical team planned for surgery to be performed on the 6th June 2022, and a GCS assessment (an assessment to objectively describe the extent of impaired consciousness) was to be undertaken.

Mr Jacka was also reviewed by the Intensive Care Consultant on the 5th June 2022 at 11:13 and it was noted that he had been intubated in the early hours of the morning secondary to type 2 respiratory failure. A plan for a pause in sedation administration to facilitate a GCS assessment prior to surgery on the 6th June 2022 was documented.

The GCS assessment was undertaken by the Intensive Care Consultant on the 5th June 2022 at 16:41. Mr Jacka was recorded to have been obeying commands whilst under sedation with a GCS score breakdown of Eyes-4 (eyes opening spontaneously), and Motor-6 (obeying commands).

In conclusion, based on the clinical information reviewed there is evidence that Mr Jacka did not suffer a hypoxic brain injury as a result of his deterioration in the early hours of the 5th June 2022. Mr Jacka

was opening his eyes spontaneously immediately after his acute deterioration, and a GCS assessment was undertaken which confirmed that Mr Jacka was able to open his eyes spontaneously and obey commands. This assessment is not consistent with a catastrophic brain injury and he appeared unchanged neurologically from his condition prior to being intubated overnight.

- ***Had the surgical and anaesthetic team known of the extent of the critical incident of 5 June, the operation would have been delayed and further tests and assessments undertaken. The anaesthetic team may have opted for elective tracheostomy if the full circumstances of the critical incident of 5 June 2022 had been known. An elective tracheostomy would have led to a different outcome because it would have avoided the complications that ensued from the attempted airway exchange.***

The decision to progress to surgical fixation of Mr Jacka's thoracic spinal injuries was made by the surgical team in consultation with the Intensive Care team and in the knowledge that he had been intubated for respiratory failure early on the 5th June. He had an appropriate clinical neurological assessment during the daytime on the 5th June and was demonstrated to be unchanged following intubation. No other investigations were deemed necessary pre-operatively by the surgical or Intensive Care teams.

Given the severity of Mr Jacka's injuries, it is likely that a tracheostomy would have been performed at some stage during his treatment, however it was not indicated prior to his spinal surgery. Tracheostomy insertion carries significant risks, especially in the context of recent cervical spine injury, and a newly sited surgical tracheostomy would have represented a higher risk of airway displacement during prone spinal surgery than an oral endotracheal tube. These factors had been considered on the 5th June 2022 as part of the decision to proceed with spinal fixation surgery first.

- ***I note the NHS Investigator and the Investigatory Panel both recommended that action is required for the handover of complex patients. The panel recommended as follows: More robust and formalised handover of complex patients before transfer to theatre, to include review of airway management, cardiopulmonary status, potential avenues of deterioration and any significant events during admission.***

- ***The Trust had chosen not to accept this recommendation but at the time the Trust made that decision it was not aware of the extent and significance of the error of omission.***

A review of the current practice for reviewing and handing over patients who require transfer from the Intensive Care Unit to the operating theatre has been undertaken. Currently patients are reviewed by the surgical and anaesthetic teams pre-operatively and information is collected and documented by the anaesthetic team using a structured Pre-operative Anaesthetic Assessment chart in keeping with standard procedures across the Trust. The anaesthetic team assess the patient and examine/record relevant information relating to the patient's history, airway assessment, cardiorespiratory system, and any diagnostic tests and results. The pre-operative assessment is undertaken to formulate a clear anaesthetic plan, but also provides an opportunity to seek additional information, optimise the patient if required, and consider if the surgery is safe to proceed. Members of the Intensive Care Medical team are present on the Intensive Care Unit 24 hours a day and can provide additional information as required. Once the patient has been reviewed by the anaesthetic and surgical team, information relating to the patient, as well as the surgical and anaesthetic plan is shared and discussed at the theatre brief prior to the start of the operating list.

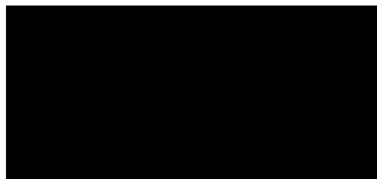
The Trust has an existing process for the handover of postoperative patients to the intensive care Unit (appendix 1), and this has proved beneficial in promoting meaningful discussion between senior

decision makers, as well as improving the quality of information that is received. The Trust is committed to ensuring that the quality of handovers is as robust as possible given the well evidenced risks, and therefore the following actions have been agreed.

> **Action 1 (due to be completed by the 29th February 2024):** The intensive care and anaesthetic department will work together to create a preoperative handover checklist (similar to the postoperative handover checklist in appendix 1) which will help ensure that the anaesthetic team collecting the patient has considered all things that are likely to be relevant to the patients ongoing care and treatment. This will include airway concerns, allergies, medications, clotting and blood products for example. This checklist would help support meaningful discussion between senior decision makers in complex patients.

I hope that this response provides some reassurance that we have fully explored the concerns raised, and that we are committed to taking the necessary steps to improve the safety of our services.

Yours sincerely,



Deputy Medical Director

Appendix 1 – Postoperative Intensive Care Handover

Postoperative Intensive Care Handover

Physical Transfer → Information Transfer → Confirmation and Care Planning

1 - Transfer Patient and Equipment

Stabilise Patient
SILENT COCKPIT
Prior to Verbal Handover

Ensure:

A	Airway secure
B	Breathing circuit attached Ventilator set and functioning
C	CVS stability Vasoactive agents running
D	Sedation running Analgesia adequate

2 - Structured Handover

Patient Information
- Name
- Age
- Allergies
- Diagnosis
- Procedure Performed
- Relevant Medical History

Anaesthetic Information
- Type of anaesthesia and course
- Complications
- Fluids administered
- Blood Products and blood loss
- Other medications given

Surgical Information
- Surgical course
- Complications
- Site information – dressings, drains, packs

3 – Confirm Information

Care Plan
- Anticipated recovery and problems
- Analgesia
- Postoperative investigations
- Fluids
- Antibiotics
- Medications
- DVT prophylaxis
- Nasogastric tube
- Feeding

Documentation
- Page 26 complete
- Drug Chart
- Surgical Note and contact Bleep
- Care Plans

Ensure all questions answered before theatre team depart