Office of the Chief Executive Officer
CEO: [redacted]

Worcestershire Acute Hospitals NHS Trust

Our Ref: [redacted]

8th February 2024

D.D.W. Reid
H M Senior Coroner
Coroner's Court
Martins Way
Stourport-on-Severn
Worcestershire
DY13 8UN

Dear Sir

Terence Hines Regulation 28 response

Thank you for forwarding on your Regulation 28 report. I have read your report with great care and note the concerns that you have raised as a result of the coronial inquiry into the death of Terence Hines.

In your report, you highlighted the following points of concern and I will respond to these concerns below, as a sequence, where appropriate.

Concerns

1) **Mr Hines had been admitted to the Alexandra Hospital on 26.5.23, where he was treated for a ruptured Baker's cyst;**
2) **On 19.6.23 Mr Hines was moved to side room 2, on ward 2 at the hospital. This room had been vacated that same day by another patient who had had a known MRSA infection and an exfoliating skin condition which, taken together, represented a heightened risk of a subsequent occupant of the room developing an MRSA infection, and therefore ought to have triggered a Red (hydrogen peroxide) clean of the room before Mr Hines moved into it;**
3) **A Red clean of the room did not take place before Mr Hines moved into the room – instead, an Amber (Chlorine) clean was carried out in error;**
4) **The Trust's investigation into the circumstances surrounding Mr Hine's death was unable to establish why no Red clean was ordered, or why an Amber clean had been mistakenly ordered instead;**

The Trust accepts that the Red clean was the appropriate clean in this case, due to the risk of environmental contamination with MRSA, and apologises for this not being carried out. On

further investigation of this issue, we found that the Trusts policy around the Red, Amber, Green (RAG) cleans was unclear and therefore there was a risk of human error.

As a result of this, clinical staff have been reminded of their responsibilities to carry out a Green clean before the Amber and Red cleans are carried out. This was done through an email sent to Infection Prevention and Control (IPC) link nurses, Ward Managers and Matrons across the Trust, as part of IPC Awareness Week on 16th-21st October 2023. In addition to this, the Record of Terminal Cleans has been updated to prompt the team to ask the nurse in charge, whether the Green clean has been completed, before they undertake the Amber and Red cleans.

The RAG poster has also been updated to include what the Red, Amber and Green cleans consist of, and this has been hand delivered to each ward by the IPC team. Each ward has signed to acknowledge receipt of these new posters, which were then discussed in the safety huddles and displayed on the wards.

In relation to MRSA, the new guidance makes it clear that we will always require a Red clean when a known MRSA colonised patient is in a side room and not just when there is an accompanying exfoliating skin condition. This will remove any potential uncertainty and make the process clear.

5) **On or about 24.6.23, because Mr Hines had now been an inpatient for28 days, he should have been screened for MRSA. That routine MRSA screen was not carried out. The Trusts investigation was unable to explain why that routine screen had not been carried out.**

The trust has now implemented both further learning and additional checks, to ensure that further routine screens are not missed.

The Divisional Management Team has reminded the Ward Teams of the requirement to carry out routine 28-day MRSA screens. This has been done in an outbreak meeting.

A pop-up reminder has now been set into the electronic patient record, Sunrise, which will pop up on day 28, to alert staff that the MRSA screen is now due.

A report has been added to the Trusts reporting network (WREN) which lists all patients who are due MRSA screening. This is a live report, which identifies patients who have had a length of stay of 28 days plus, who do not have an MRSA screen. The IPC Team now use this report to monitor MRSA screening and escalate relevant cases to the ward teams when required.

There is also a report under construction to review the Trust compliance with MRSA admission screening and 28-day MRSA screening that will be monitored via the Trust Infection Control Committee and the Divisional Governance meetings.

6) **On 26.6.23 Mr Hines suffered an accidental fall in the room and was found to have sustained a fractured right neck of femur. As a result, he was transferred to Worcestershire Royal Hospital where surgery to fix the neck of femur fracture was carried out on 1.7.23.**
7) **As a matter of established routine, Mr Hines should again have been screened for MRSA prior to his surgery. Once again, that routine MRSA screen was not carried out. The Trusts investigation did not explore the question of why that routine MRSA screen had not taken place.**

The Trust has identified that although it was routine practice to screen for MRSA prior to surgery, the peri-operative checklist form did not include the MRSA status, or infection status of the patient. This therefore meant there was nothing to prompt the clinicians, leaving room for human error. The Trust has now updated the form so that it includes this information, to ensure that clinicians are routinely prompted to check the MRSA status.

In addition to the updated checklist, the Deputy Director of Infection, Prevention and Control attended the Surgical Division Board meeting and have shared the report with the Team, to raise awareness of the requirement for MRSA status to be confirmed prior to surgery. If MRSA status is not known, then decolonisation treatment will be commenced to alleviate the risk.

The IPC Team have also implemented a real time Monitoring and Surveillance process. MRSA results are imported into ICNET (infection control software program). IPC Nurses review the results and follow-up. This enables oversight and escalation of results. When a patient has been discharged before the results are available, IPC will send a letter to the GP, which sets out recommendations for decolonisation if required. The wards are informed if the patient remains an inpatient, and advice and guidance is given to the ward teams. Decolonisation is always required for inpatients with MRSA going for surgery.

For outpatient, the pre-admission swab for elective surgery is valid for 18 weeks. Decolonisation is recommended for new MRSA cases and known MRSA cases.

Prophylactic antibiotics should be risk assessed for any patients that are known MRSA or newly diagnosed if going for surgery.

8) **Mr Hines was eventually screened for MRSA on 3.7.23 (after his surgery) and a couple of days later, the results of that screen confirmed that he had tested positive for MRSA. He was started on decolonisation treatment on 6.7.23.**
9) **A few days after his surgery, Mr Hines developed an infection around his surgical wound, and sepsis. He was returned to theatre on 12.7.23 for debridement and washout of the surgical wound. Analysis of swabs from the wound, and blood cultures, both taken during this procedure, showed the presence of MRSA, and**

that the MRSA matched that of the previous occupant of his side room at the Alexandra Hospital;

10) **Despite treatment, Mr Hines died at Worcestershire Royal Hospital on 15.7.23. The cause of death was:**
1a sepsis
1b infected surgical wound (methicillin resistant staphylococcus aureus)
2 heart failure and chronic kidney disease

11) **Had side room 2 on ward 2 at the Alexandra Hospital received the required Red clean before Mr Hines moved into it, he would probably not have developed the MRSA infection, and would probably not have died when he did.**

The Trust would like to sincerely apologise for the errors made and has reflected on its practices as a result of Mr Hine's death.

In addition to the changes set out above, the trust has updated the Isolation Policy to reflect the new process of a Red clean for every known case of MRSA, and a "lessons learned poster" has been distributed to wards to highlight all of the learning from this incident.

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into the death of Terence Hines.

Should you require any further information in relation to this matter, please do not hesitate to ask.

I confirm that I have not forwarded a copy of this response to any other Interested Person and would therefore be grateful if you could do so, as appropriate.

I also confirm that the Trust is content for both the regulation 28 report and the response to be released or published should the Chief Coroner wish.

Yours sincerely

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[redacted]
Chief Executive