South Tees Hospitals
NHS Foundation Trust

Group Chief Medical Officer
The James Cook University Hospital
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14 March 2024

[redacted]

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By Post:

Private & Confidential
Ms C Bailey
Senior Coroner
HM Coroner's Office
Middlesbrough Town Hall
Albert Road
Middlesbrough
TS1 2QJ

Dear Ms Bailey

Inquest into the death of Miss Kate O'Donnell

I write further to the above Inquest and in response to your report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 22nd January 2024, issued to South Tees Hospitals NHS Foundation Trust.

A number of the issues raised are linked, and therefore I have grouped them together in order that I can respond to the concerns in full.

1. Planning for the operation was poor and resulted in the non-attendance of a colorectal surgeon at the surgery.

It is recognised that the combination of surgical approaches required was rare, and therefore bespoke arrangements were required to plan for Kate's surgery. Kate was having an ACE (antegrade continence enema) stoma removed. These stomas are generally created in patients with spinal problems that prevent good bowel control and often then used lifelong. Unfortunately in Kate's case, this had not completely resolved issues, she had required a colostomy, and had had prior infection linked to the ACE

stoma, hence the decision to remove it. To try and minimise the inconvenience to Kate, this was combined with another planned urological procedure requiring anaesthetic.

The Consultant Urologist wrote to the Consultant Surgeon on two occasions regarding Kate's surgery. This was to discuss whether help would be required from the Consultant Surgeon in case Kate's bowel needed to be mobilised during the surgery. The ACE stoma removal was a similar, but less invasive surgery to an appendectomy. The Consultant Urologist and General Surgeon had a verbal conversation and agreed that full bowel mobilisation and/or laparotomy was not required as the ACE stoma could be accessed via the abdominal wall exit site, and as such the procedure could be undertaken by the Consultant Urologist. Unfortunately, this conversation is not recorded in the medical notes, and although both parties confirm it occurred, neither can confirm the date. However, the coroner's statement provided by the Consultant Urologist highlights that the conversation took place on the day of surgery.

Appropriate surgical planning did take place but recording of decision making was poor and this was amplified with difficulties accessing notes in a timely manner. The Trust has now implemented an Electronic Patient Record system and has started to scan all historical records to link with this, which will prevent recurrence of this issue in future. The introduction of an electronic clinical noting system will also help prevent the other documentation errors that occurred in this case, referenced below, ensuring an electronic signature, date and time are linked to every note entry.

2. The Consultant Urologist did not know the results of pre-surgery urine test results and subsequently prescribed incorrect prophylactic antibiotics post urology surgery.

3. The consultant urologist was not aware of the classification of surgeries and didn't know that surgery could be clean-contaminated. He did not know of the SIGN guidelines and that prophylactic antibiotics were highly recommended for this type of gastro-intestinal surgery.

4. The consultant urologist overlooked the provision of prophylactic antibiotics for the gastro-intestinal surgery.

Before Kate's surgery, there was robust pre-assessment undertaken by a specialist nurse, when her results were reviewed, and the abnormal urine sample result was flagged in advance of her surgery. However, there was then a failure to take appropriate action as a result of a number of human factors, which included distraction.

The Trust's Adult Antimicrobial Policy reflects NICE guidance (2020), which recognises the need for prophylactic antibiotics following the completion of surgery involving clean-contaminated wounds, involving the genitourinary or alimentary tracts. As SIGN guidelines are Scottish, these are not necessarily applicable, and we would expect our clinicians to be aware of ,and apply, NICE rather than SIGN guidance.

There is some evidence that the Consultant Urologist was aware of this requirement, as it is set out in his second statement, dated 30th August 2022, but without Kate's notes he could not confirm which antibiotic was given as prophylaxis but "suspect I would have asked for Gentamicin …and also Co-Amoxiclav as were also removing the appendix ACE stoma as this would be the standard prophylactic antibiotic for such a procedure". However, we know that Kate was initially prescribed a dose of Gentamicin during her surgery, then Ciprofloxacin, neither of which were in accordance with Trust policy.

An audit of compliance with Trust antimicrobial guidance has been undertaken within the Digestive Diseases, Urology and General Surgery Services Collaborative throughout February 2024, which has identified areas for improvement in relation to antimicrobial prescribing. Detailed findings of the audit will be shared with the Collaborative in early April 2024, and this clinical risk will also be discussed within the Clinical Policy Group in April 2024, which is attended by senior Clinical Leaders from across the Trust.

The Trust's Adult Antimicrobial Policy will be updated by the end of April 2024 to include links to the MicroGuide Antibiotic Prescribing Guidelines app, which is a tool used to publish and provide easy access to local antimicrobial guidelines, to facilitate timely access to advice of effective and safe treatment of infections.

Additionally, the Trust Pharmacy team will create specific drug order sets within the recently implemented Electronic Prescribing and Medicines Administration (ePMA) system, to support standardised and structured prescribing for first and second line prophylactic antibiotics following surgery. This will be completed by the end of April 2024.

5. There was insufficient vigilance and recognition given to Kate's post-operative presentation, considering Kate's vulnerabilities, comorbidities, and extensive past involvement with the medical teams.

8. Case notes included details of a meeting on 14.03.22 which did not take place and was a telephone call.

There is an entry made in Kate's hospital records by the anaesthetist. The entry is not signed, but it is dated 14 March 2022. Kate's mum recalls that this review took place over the telephone and not face to face, however the anaesthetist has documented "seen in clinic" at the top of the entry. It is likely that the anaesthetist is referring to the fact the Kate was seen in the pre-assessment clinic, but we are unable to check this as the entry is not signed. The anaesthetist should have made it clear within their documentation that their review was virtual and undertaken as a telephone consultation.

From review of the pre-assessment documentation, including extensive nursing documentation from 11th March 2022, there appears to have been a robust and

thorough consultation undertaken which took Kate's medical condition into account. The virtual anaesthetic review took place on 14th March 2022 which contained a minor documentation error.

6. Kate was not physically assessed by a doctor prior to discharge.

There is a written record of a ward round in Kate's health care records, which has been incorrectly dated as 16th March 2022, when it does in fact relate to 17th March 2022. The entry states that it is "day one" following surgery, which is always the day following surgery and it also states "home today" which would also indicate that the ward round is from 17th March.

The nursing documentation discharge checklist also indicates that Kate had been seen by a doctor prior to her discharge. It is possible that the medical staff undertaking the ward round did not introduce themselves by role, and therefore it was not apparent to Kate's parents that she had been seen by a doctor that day.

7. The nursing notes did not include relevant information, to include Kate vomiting and that she was in pain. The pain scores were under stated.

9. The nursing team did not respond to repeated statements that Kate was in pain-she was not offered pain relief nor was medical help sought.

On review of Kate's health care records, there are numerous entries which state that Kate was not in pain. I acknowledge that Kate suffered with chronic pain, and it is possible that the pain scores reflected Kate's current pain (as a result of the surgery) rather than her chronic pain. The dates and times when pain was scored are shown in the table below, in addition to the times Kate was provided with analgesia.

Date	Time	Kate's pain score
16/03/2022	13:10	0
Administered 1g paracetamol	17:40	
	19:27	2
	21:56	2
Administered 1g paracetamol and 10mg oral morphine	22:15	
17/03/2022	01:21	2
	05:36	0
Administered 1g paracetamol	06:50	
	09:03	0
	12:03	5

In order to improve the accuracy and effectiveness of the assessments of our patient's pain scores, these are now undertaken at each set of physiological observations; this

is mandated as part of the electronic observation system. To enhance this further, work has been undertaken to incorporate a more detailed objective pain assessment in those patients reporting moderate to severe pain with an associated numerical score of >4. In these instances, the Abbey pain chart (measurement of pain in people with dementia who cannot verbalise) and FLACC (Face, Legs, Activity, Cry, Consolability) pain scale will immediately launch with a visual alert. Trust compliance with timely pain assessments and re-assessments are monitored on an ongoing basis by the Deputy Chief Nurse.

10. The family were not provided with information upon discharge as to what signs to look out for and what steps to take if Kate was to deteriorate.

A conversation should have taken place to advise Kate's parents of the signs and symptoms of sepsis however on this occasion this did not happen. One of the actions completed as part of the Serious Incident investigation was to develop a sepsis awareness information card which is now given to patients/carers post operatively.

In addition, the Trust is an early adopter of the 'Call 4 Concern' initiative which enables patients and their family members to contact the Trust's Critical Care Outreach team to ask for a review if they are concerned about their own condition or that of their relative. This was implemented in November 2022, and work is ongoing within the Trust to ensure that patients and their families are aware this option is available to them.

I would like to thank you for highlighting these matters of concern, and for giving us the opportunity to respond. I hope this response provides you with assurance that your concerns have been addressed by the organisation. On behalf of the Trust, I would once again like to express my sincerest condolences to Kate's family.

Yours sincerely

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Group Chief Medical Officer