University Hospitals Birmingham
NHS Foundation Trust

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10 July 2024

[redacted]

FAO Assistant Coroner Rebecca Ollivere for Birmingham and Solihull

By way of email only: [redacted]

Dear Ms Ollivere

Inquest touching the death of James Patrick Pearson
Response to Regulation 28 Report to prevent future deaths.

I am writing in response to the Regulation 28 notice issued following the conclusion of the inquest on 2 May 2024, into the death of Mr Pearson on 22 October 2023 at St Catherine's Hospice, Preston.

We have carefully considered the concerns raised within your report to prevent future deaths and our response is set out below.

Unfortunately, the report presented at inquest mistakenly stated the unit was a Major Trauma Centre, which it is not and should have advised it is a Trauma Unit. I would like to apologise for this error in terminology and assure you the report has been revised to clarify this point.

<u>Lack of documented observations</u>
During the Inquest you heard evidence that whilst Mr Pearson was attached to a monitor which was taking his observations every 15 minutes, these were not being documented and you are concerned that the lack of documented observations could result in a failure in identifying a deteriorating patient.

The Trust adheres to RCEM standards for observations, which are as follows:

"STANDARD 1: Patients triaged to the majors or resuscitation areas of the ED should have the following measured and recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest:

- *respiratory rate*
- *oxygen saturation*
- *pulse*
- *blood pressure.*
- *GCS or AVPU score*
- *temperature*

STANDARD 2: Patients with abnormal vital signs should have their vital signs repeated and recorded in the notes every 60 mins from first set of observations.

STANDARD 3: There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present).

STANDARD 4: There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases".

Whilst observations are not documented every 15 minutes, they are monitored and any trigger actioned according to the Trust Acutely Ill Adult NEWS2 Procedure AcutelyIllAdultsNews2Procedure.pdf. (NEWS2 is a standardised National Early Warning Score devised to standardise the assessment and response to acute illness or deterioration.)

Following an alert, there are periods of time when a patient may be undergoing imaging outside of the Emergency Department; these observations will still be monitored but not recorded via PICS, which is relevant to this case.

During an alert when there is ongoing dynamic assessment and resuscitation, staff are not expected to document contemporaneously but do document an account of observations and actions taken as per RCEM and Trust standards. It should be noted that PICS does not permit the retrospective entry of observations on the chart.

The standards set out above and expected documentation has been reiterated at Emergency Department huddles to ensure that recording within noting is robust and will be audited as part of the action plan following this Serious Incident Investigation t provide assurance that these standards are being adhered to.

Medical resourcing of the Trauma Unit/ED

We regularly review our workforce numbers in conjunction with best practice guidance and benchmarking. We have participated in the RCEM England census to benchmark our doctors' numbers, we have also utilised NHSE tools to review our rota patterns against attendance numbers with the aim of achieving resilience to the 75th centile of attendances.

We have reviewed the rotas for both 13 June 2023 and 14 June 2023.

Mr Pearson arrived in ED in the period covered by the night shift rota for 13 June 2023. We use RCEM recommendations on tiers to produce our standardised rota patterns for Heartlands Hospital, which as stated above is a Trauma Unit.

Our standard ED night staffing at BHH is for:

- For an ED (non-MTC) with >100,000 attendances a year, one consultant overnight on call, and one senior decision-maker (does not have to be a consultant) in the EPIC role is recommended for a night shift (RCEM 2019).
- 1 tier 4 doctor (highlighted in orange on the rota as a standard clear indicator of doctor in charge)
- 3 additional tier 3 or tier 4 doctors.
- 4 Tier 2 doctors
- 1 Emergency nurse practitioner (ENP) for minor injury only

On the night in question, we have observed that the minimum staffing was met, with an additional tier 2 doctor and an additional ENP.

To ensure we continue to meet minimum staffing levels in the ED there is a twice weekly forward look meeting with the rota team to confirm minimum numbers are met, and to be aware of where there are dips in cover and these undergo a process of escalation via the ED general manager in order to consider all mitigation options including agency use, locum, support from other specialty teams at middle grade level as examples.

The rota team consists of the following:

- 1 ED rota manager lead
- 3 additional ED rota team admin support assistants
- 1 consultant lead for Junior Doctors' rota

Whilst we are satisfied that our current model provides resilient staffing to the mean attendance profile and that our processes enable resilience of staffing with clear escalations where minimum staffing is predicted to not be achieved, we are currently reviewing the demand and capacity for the unit. This is to ensure our staffing is modelled correctly to ensure the baseline for the substantive workforce is correct. Although we meet RCEM criteria in terms of staffing on duty, to meet this we utilise a number of bank staff. The demand and capacity modelling will ensure the unit has identified what the substantive workforce should look like, to provide additional resilience. This work will be completed by August 2024.

<u>Availability of blood products within the emergency department</u>
You heard evidence that it can take up to 20 minutes to obtain blood products within the emergency department following activation of the major haemorrhage protocol. Whilst this delay was unlikely to have affected the outcome for Mr Pearson, you are concerned that delays in blood products being available could result in future deaths.

The recommendation to consider a blood fridge in BHH ED has been discussed in the Hospital Transfusion team. There are significant consequences to putting a fridge in the ED at BHH, not least that group O blood (which is what would need to be in the fridge if it is being used to support immediate transfusion) is in short supply nationally and needs to be used only for those patients that require it. This includes not stocking it in locations where it is unlikely to be used, which includes EDs (such as Heartlands) which are not in Major Trauma Centres.

Whilst the report to the coroner identifies that the delay was in requesting blood/activating the Major Haemorrhage Protocol (MHP), once this was done the blood arrived quickly. The blood arrived within 15 minutes which is the time stipulated by our Trust procedures and recognised to be acceptable against national norms.

A review of all incidents involving activation of the MHP within Heartlands Emergency Department since Mr Pearson's death has been undertaken. This did not demonstrate any incidents regarding delays in receipt of blood once the MHP was activated. A full audit is underway by the Hospital Transfusion Group to review overall compliance to the Major Haemorrhage Blood Protocol across all UHB sites, the outcome of this will be reported to the Trust Transfusion Committee.

I would like to assure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously, which I hope is demonstrated in the steps that have been taken following Mr Pearson's death.

Yours sincerely

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Chief Executive