York and Scarborough
Teaching Hospitals
NHS Foundation Trust

Chief Executive Office
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[redacted], Chief Executive
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19 December 2024

Ms C Cundy
HM Coroner for York & North Yorkshire
By email: [redacted]

Dear Madam

Thank you for raising your concerns following the inquest surrounding the death of Mrs Janet Seddon following her admission to York District Hospital. I am grateful for the extension of time for providing this response. York & Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) recognises the seriousness of these findings, and I write to outline the actions we have taken to address the lapses identified. These measures are intended to reduce the risk of recurrence and improve the quality and safety of care provided to our service users. I note your concerns as outlined in the Preventing Future Deaths Report.

It is to be noted that at the time of the incident the Trust followed its previous policy on incident management. The Trust moved to the new Patient Safety Incident Response Framework (PSIRF) in December 2023. Since that time revised systems and processes have been put in place to record, monitor, review and learn from incidents across the Trust. It is acknowledged that this incident should have had, under the old policy, a 72-hour report, and this was not undertaken. This has been reviewed within the Surgery Care Group and the new policy requiring either hot debrief or other form of incident response is now in place and is being used to proper effect. The governance structure within the Care Group, to review incidents, has significantly changed with a daily review of all incidents and weekly escalation process to Care Group Governance Lead (Consultant Anaesthetist) and Associate Chief Nurse.

Following the introduction of the new PSIRF framework the Trust updated the Incident Management Policy and Procedures (March 2024) and its Duty of Candour Policy, now called Compassionate Engagement and Duty of Candour Policy (June 2024) which are available should you wish to have sight of them.

I will address your specific concerns as follows:

3a) the very significant delay in addressing whether the missed abdominal pathology was the result of a reporting error;
3b) the absence of any proper assessment of harm caused to Mrs Seddon as a result of the error;

When the possible radiological misinterpretation on the CT scan was identified on 07/02/2023 this was acted upon immediately, and Mrs Seddon underwent surgery the same day. It is accepted that following this immediate response, there was a delay in confirming whether this was a radiological error (as opposed to a discrepancy) and, once this was identified, a further delay in confirming the level of harm.

The radiology reporting team are encouraged to report discrepancies as part of a learning and improvement culture and communications have been regularly reviewed in this regard. Following this case being highlighted to the team there is now a much-improved awareness of, and engagement with, the discrepancies process.

The Trust Radiology Duty of Candour Standard Operating Procedure (SOP) (available should you wish to have sight of this) describes how discrepancies are assessed to establish if radiological errors have occurred and how these are then disclosed to clinicians to evaluate degree of harm and inform duty of candour conversations if required. This SOP is in line with, and applies, national Royal College guidance to our processes. It was last revised in July 2024, before this inquest, and that update included specifying the one-week turnaround timeframe for reporters responding to a candour panel, improving efficiency from the Radiology side of the process, and a two-week response timeframe for treating clinicians to respond to Radiology letters disclosing confirmed radiological errors and requesting feedback on the degree of harm. A governance structure for reporting and escalation was added for discrepancy cases which involves the review of incidents at the weekly Senior Leadership Team (Assistant Chief Nurse, Assistant Chief Operating Officer, Care Group Director and the governance team) meetings, where the lack of feedback on the level of harm can be escalated.

Further updates to the SOP have been developed to clarify that the receiving treating clinician's Care Group governance team should be copied into the initial correspondence to the clinician, and if required escalation for feedback on level of harm will take place with the Cancer, Specialist and Support Services (CSCS) Care Group Director contacting the Director of the respective Care Group. This will ensure a more timely outcome regarding level of harm and in turn a duty of candour conversation with patient and/or family with the treating clinician, supported by a radiologist. These updates will be submitted to the next Radiology Directorate Meeting and on approval to CSCS Care Group Board for virtual agreement on 12/12/24.

3c) the delay in clear disclosure of the error to Mrs Seddon's family and to the Coroner;

The surgeon reports that he was open with the patient about the missed pathology and the need for second scan but the significance of this was unknown at the time. It was noted that the patient had full capacity, and she was very clear with the surgeon that she did not want

her family to know that she was going for surgery. This was explained to the family following her death via a letter sent to them on 13/02/2023. However this did not make reference to a radiological discrepancy.

The incident form provided to the Coroner on 26/02/24 confirmed that there had been a radiological error. As this had (incorrectly) been deemed a low harm incident, statutory duty of candour did not apply.

3d) the absence of evidence that all relevant learning arising from the above has occurred and any actions arising from such learning have been completed;

This case was discussed at the Radiology Events and Learning Meeting (REALM) in November 2023. Minutes are not kept as per Royal College of Radiologists guidance and all cases are anonymised, to encourage open discussion. Attendance at REALM is high within the Trust and participation is monitored and discussed at individual reporter's annual appraisal.

e) the potential risk of death to others in the event of a recurrence of any of the above.

As outlined above our processes for reviewing and learning from potential radiological errors, and fulfilling duty of candour where required, have been strengthened. We also have in place a revised Incident Management Policy and a revised Duty of Candour Policy further strengthening our systems and processes.

Conclusion

We hope that this information provides you with assurance that the Trust takes its responsibilities to be open and honest with patients very seriously. We have a number of systems and processes in place to ensure that these are effective. The Trust has learned from this incident and have refined our processes as a result. This will continue to be monitored carefully through our governance and assurance structures.

Yours sincerely

[redacted]

[redacted]
Chief Executive