Northern Care Alliance
NHS Foundation Trust

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31 December 2024

Mr M J Pemberton
His Majesty's Assistant Coroner
HM Coroners Court
First Floor Paderborn House
Howell Croft North
Bolton
BL1 1QY

Dear Mr Pemberton

Re: Inquest into the death of Anne Taylor – Regulation 28 Report

I write following receipt of your report to prevent future deaths and to hopefully assuage your concerns that prompted it. At the outset I would like to take this opportunity to offer my sincere condolences to Mrs Taylor's family for their loss.

Thank you for bringing the concerns raised in the Regulation 28 report to my attention. Your concerns were as follows:

1. *During evidence, it was heard that the deceased had elected to leave the Hospital on Friday 19 July because of waiting times, before being clinically assessed.*
2. *There was no consideration of whether secondary investigations could be undertaken during the waiting time for example CT scan which would likely be required by a clinician to make a diagnosis.*
3. *No evidence was provided that the deceased's mental capacity to decide to leave the hospital was assessed given the history of suspected head injury.*
4. *Reference was made to a new standard operating procedure being developed relating to patients leaving the hospital before a clinical assessment occurs, but it was unclear what this will include.*

I understand that following Mrs Taylor re-attending hospital on 20th July 2024, and the diagnosis of acute subdural haematoma being made, a clinical incident was immediately reported by a nurse in the Emergency Department regarding the ED attendance the previous evening. This incident was triaged via our usual governance systems, and it was felt that although an earlier diagnosis would sadly not have changed the outcome for Mrs Taylor, there was an opportunity for learning and improving our systems and so an After-Action Review was undertaken under the Patient Safety Incident Response Framework (PSIRF).

The review determined that going forwards secondary investigations (such as a CT scan) should be considered and frontloaded for patients who are identified as meeting NICE guidelines criteria for CT scan in head injury, whilst they await clinical review. The new NHSE Acuity tool process described below will support this.

Additionally, it was highlighted that at the time of Mrs Taylor's attendance there was no formalized Standard Operating Procedure within Salford Royal's Emergency Department defining the actions to take when a patient leaves before clinical assessment. Salford site has an electronic self-discharge checklist designed for ward-based use, but no guidance or policy to describe the appropriate completion of this, or relevant steps to take, in the emergency department setting.

A Standard Operating Procedure (SOP) for patients who leave the emergency department whilst waiting to be seen has now been drafted and is going through NCA approval processes, with an estimated approval date of 6th February 2025. We append the working draft for your information. This guideline sets out the responsibilities of clinical and nursing staff when an adult leaves an emergency care setting prior to being assessed or receiving treatment, so that the patient is safeguarded appropriately with the aim of:

- Ensuring patients receive appropriate healthcare.
- To help identify patients who are at risk of coming to harm.
- Ensuring patients have the mental capacity to and are supported to make their own decisions regarding their care.

Once approved the SOP will be shared with all urgent and emergency care areas for dissemination. In the interim, learning from the incident and draft SOP will be circulated through safety messages and in the directorate governance meeting.

Within this new SOP, it is made clear to nursing and clinical staff that it is their responsibility to assess mental capacity for patients stating they want to leave and to escalate any concerns appropriately. Patients who wish to take their own discharge and are assessed to have the mental capacity to do so, should be safety netted, with NCA leaflets related to their presentation and verbal advice as indicated. The documentation review, actions taken, and record of discussions, should be clearly documented in the patient's notes.

In addition to the above, as of 25th November 2024, Salford Royal Hospital has become an early adopter of the NHSE Acuity Tool, an initial assessment model which aims to standardize the measurement of acuity in Emergency Departments and Urgent Treatment Centres. Patients who attend the ED at Salford Royal now receive an initial, primary assessment to identify patients with an acuity 1, 2 or 5 which will allow them to either be directed immediately to a receiving location or be directed to an alternative provider such as primary care. Acuity 1 patients are those with immediate life/limb threatening illness/injury, acuity 2 are those with imminent life/limb threatening illness/injury and acuity 5 denotes no threat to life or limb, no ED specific resource necessary. Patients who do not meet an acuity 1, 2 or 5 will then go on to receive a secondary assessment. The target time for secondary assessment is 15 minutes, Salford Care Organisation are on track to achieve this. Progress of the early adopter programme is being shared with NHSE at regular intervals. Patients receiving a secondary assessment can be identified for early clinical intervention and front loading of essential investigations such as, CT scan. Work is ongoing to meet the NHSE secondary assessment target to provide the significant benefits it offers of reducing the risk of patients with serious conditions sitting in the waiting room for a long time undiagnosed. In addition, the new acuity tool, has a specific question regarding mental capacity assessment relating to a patient's decision to leave the department.

The Trust is always open to the opportunity to review, and where possible, strengthen our processes. I hope this response offers assurance to you that the Trust has continued to take these concerns seriously and has put in place a number of steps and actions since the tragic death of Mrs Taylor.

Yours sincerely

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Chief Executive Officer