☎ [redacted]
✉
Ref | Regulation 28: Charlotte Roscoe

NHS
Bolton
NHS Foundation Trust

Trust Headquarters
Royal Bolton Hospital
Minerva Road
Farnworth
Bolton
BL4 OJR
www.boltonft.nhs.uk

4th February 2025

For the attention of HMC Mr Pemberton
HM Assistant Coroner for Manchester (West)
HM Coroner's Office
Paderborn House
Howell Croft N
Bolton
BL1 1QY

Dear HMC Mr Pemberton,

Thank you for your letter dated 20th November 2024 issuing your Regulation 28: Report to Prevent Future Deaths of the same date concerning the sad death of Ms Charlotte Roscoe ('Charlotte') on 22nd January 2024. In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to Charlotte's family and her loved ones.

Bolton NHS Foundation Trust (the Trust) are keen to assure the family and HM Coroner that the concerns raised regarding Charlotte's care have been listened to and reflected upon. We have set out below the Trust's response in accordance with Regulation 29(5) of The Coroners (Investigations) Regulations 2013.

For ease of reference, the following items were identified as matters of concern in the Regulation 28 report:

1. *During the course of evidence Royal College of Radiographer guidance was referred to, specifically that a CTPA scan or VQ scan where equally appropriate when considering diagnosis of a Pulmonary Embolism. A first draft of an After Action Report which was concluded without Radiographer attendance at the after action review meeting was provided at the first part heard inquest hearing on 1 August 2024. This made reference in the actions section of the report to the need to consider whether VQ scans should be replaced by CTPA's for all patients suspected of having a Pulmonary Embolism. This action was not included in an Amended After Action report provided at the resumed inquest. It is unclear whether this matter has been considered.*

2. *Evidence was received from a doctor who referred the deceased for a scan, that she had thought she had requested a CTPA to be undertaken, but the form that was used was a request for an 'acute pulmonary embolus investigation' which meant that the request would be vetted, and an appropriate mode of scan arranged following consideration by a radiologist. It was stated by the doctor that it would not be normal to speak to radiology regarding a request for a scan.*

3. *In evidence from a radiologist, it was stated that a medical clinician would be expected to speak to a radiologist if there was any preference for a type of scan to be undertaken so this could be discussed. It appeared to me that the use of the correct form, need to be specific, provide rationale for a specific type of scan request, and liaising with radiology as appropriate was not appreciated in*

this case. As above, given that there was no radiographer involved in the After Action Report or action raised, it is unclear if this matter has been considered, or any actions taken to prevent future confusion.

<u>After Action Review (AAR) – responding to points 1 above:</u>

The Acute Adult Care Division was made aware of a complaint from Ms Jayne Roscoe (Charlotte's Mother) on 13th February 2024 and a clinical incident was reported retrospectively by the Divisional Medical Director.

On initial review there did not appear to be any concerns in relation to the standard of care provided to Charlotte. However, it was felt further investigation was required given Charlotte's age and the fact she had been in attendance and discharged from the Emergency Department (ED) just 24 hours prior to her death.

The decision at this stage was to request a mortality review of Charlotte's care and treatment whilst she was in the ED and to continue to investigate Ms Roscoe's concerns via the Trust's complaints process. The plan was that if the mortality review identified any concerns regarding the care provided then this would be escalated as a PSII (Patient Safety Incident Investigation) in line with the NHS England (NHSE) Patient Safety Incident Response Framework (PSIRF).

The outcome of the mortality review was that Charlotte's care was rated as 'good' and therefore the case was not escalated for a PSII and the Trust continued to investigate Charlotte's care via the complaints process. A complaint meeting was held with Charlotte's mother on 23rd April 2024 to provide full answers to all questions raised in the complaint. A full recording of the meeting and a follow-up letter summarising the outcome of the meeting was provided to the family as per standard process.

An area of concern discussed whilst investigating the complaint was in relation to the decision to discharge Charlotte from the ED without further investigation into her raised troponin levels or d-dimmer results and therefore an alternative diagnosis / treatment was not explored. As a result, the Acute Adult Care Division decided to undertake a focused After-Action Review (AAR), chaired by the Divisional Medical Director, specifically to explore this decision making and to consider whether this was reasonable based on clinical information available at the time.

AARs are one of the learning response tools under PSIRF, and this framework encourages organisations to adopt a proportionate response to patient safety incidents for learning and improvement. As such, it was felt an AAR was the appropriate learning tool to facilitate a conversation for that very focused key area. The review explored whether clinicians, with a similar set of experience and knowledge, would have made the same decision faced with the same clinical scenario. The invitations to participate in the AAR meeting were therefore sent to all the Acute Divisional Medics, as they would be best placed to consider this specific area of potential concern. Consequently, it was not deemed necessary for a radiologist to attend.

AARs are structured, facilitated discussions conducted after an event or activity to assess what occurred, why it happened, and how future outcomes can be improved. The PSIRF makes no prescription to determine what needs to be learned from to inform organisational improvement, and incident response activity may include investigation of an individual incident where contributory factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan.

The AAR concluded, in Charlotte's case, that assessments carried out, including investigations and treatment, were felt to be in line with expected practice. The working diagnosis was Pulmonary Embolism

(PE), and this was felt to be reasonable based on Charlotte's clinical presentation. When this was excluded, Charlotte had reported that her pain had improved, resulting in the decision to discharge. At no stage was there any consideration of aortic dissection due to its rarity, Charlotte's lack of risk factors and her atypical presentation.

Constructive challenge was applied to the clinicians using the Bolam / substitution test; all clinicians came to the same conclusion that with the facts presented they would have carried out the same actions and discharged Charlotte from the ED.

The AAR was approved through the Divisional Governance Board, which is the standard governance process. The potential area of learning regarding whether a CT Pulmonary Angiogram (CPTA) scan should be considered in place of a VQ scan for all patients suspected as having a PE, was shared with radiology via the Diagnostic and Support Services Division governance processes for their consideration. The AAR was then disclosed to HM Coroner as per the usual disclosure processes.

At the first inquest on 1st August 2024 matters had arisen in evidence including "*identification of omissions and errors in an after-action report which reviewed the circumstances of Charlotte's death*"[1], and it was directed that further evidence was required. Additionally, the Trust was to provide to HM Coroner *'any update on the AAR conclusions and recommendations*[2]*'.*

Consequently, the Acute Adult Care Division sought advice from the Director of Quality Governance as to whether to amend the existing AAR or to completely revise the document. The advice was that the original AAR required an addendum to show the findings from the further investigations and to address the lack of observations before discharge, rather than completing a full new AAR. It was further felt that the additional Radiology evidence and attendance of the Consultant Radiologist and former Governance Lead of the Radiology Department at the inquest would provide clarity and assurance around the appropriate scan being performed at the time based on Charlotte's presenting symptoms.

The addendum was completed by the original AAR author and approved through the Divisional Governance Board. The action regarding "*the need to consider whether VQ scans should be replaced by CTPA's for all patients suspected of having a Pulmonary Embolism*" was removed from the report. This was because following consideration, the Radiology team did not feel the proposed learning / action was appropriate on the basis it departed from National guidance. On reflection, the Trust acknowledge that it would have been clearer to have kept the original action documented, and updated the outcome of it, rather than it being removed completely.

It should be noted that the AAR was not a PSII; it was supplementary learning to the already completed mortality review and complaint investigation.

<u>Radiology Requests – point 2 and 3 above:</u>

The request card/form used in the ED is for a referral for a scan to exclude PE. The radiologists are the experts who determine the modality based on the Ionising Radiation (Medical Exposure) Regulations (IRMIR); the technical nature of the imaging and the clinical question posed. The form used clearly states that the scan is to exclude a PE and is not a specific form used to request a specific scan or modality. This form has been used in the trust for several years.

[1] Adjournment Directions dated 1 August 2024
[2] Adjournment Directions dated 1 August 2024

Many of the clinical pathways follow a set protocol based on National guidance, an example being head injuries and NICE guidelines. These set protocoled pathways do not require discussions between ED clinicians and Radiologists. Excluding PE is a standardised pathway in the Trust and has been the case for many years. If a clinician seeks to depart from the set protocols or National guidance/recommendations, then they must have a discussion with the examining (vetting) Radiologist to explain and discuss the rationale. With a patient presenting similarly to Charlotte, the recommendation from the Royal College of Radiologists would be for a V/Q scan. If a CTPA was specifically required, this would not be the primary modality of choice and would require further discussions between the requesting clinician and Radiology to understand why a CTPA was warranted over a V/Q scan. This is custom and practice across the region.

I would like to thank you for bringing your concerns to our attention and I hope this response provides some clarification.

Should you have any further questions, please do not hesitate to contact me.

Yours sincerely,

[redacted]

[redacted]
Chief Executive