



29 January 2025

Mrs Louise Hunt
Senior Coroner for Birmingham & Solihull.

BY EMAIL TO: [REDACTED]

Dear Mrs Hunt

Inquest touching the death of Michael John Thompson - Response to Regulation 28 Report to Prevent Future Deaths

I am writing in response to your report issued pursuant to Regulation 28, following the conclusion of the inquest on the 5th of December 2024 into the death of Mr Michael John Thompson.

We have carefully considered the matters of concern raised within your report to prevent future deaths, and summarise these as:

- 1. Surgery Complication:** A defect in the peritoneum occurred during surgery and was repaired, but this was not recorded in the operation note, raising concerns about record keeping.
- 2. Investigation Focus:** The Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF) process only addressed resuscitation efforts and did not address the peritoneal defect, raising concerns about the adequacy of the Trust's investigations and its ability to learn from deaths.

Matter of Concern 1 - record keeping

In response to this concern, the Trust acknowledges and accepts that the operation note did not document the management of the peritoneal tear when the tumour was removed. We also accept and acknowledge that this omission was not identified as part of our PSIRF investigations.

In terms of immediate learning, the Trust has taken steps to ensure there has been professional reflection around delegation and documentation at individual and team level. The Chief Medical Officer has discussed this notice and the importance of clear documentation with the clinical body at the Trust's Audit, Morbidity and Mortality meeting.

To further address this concern, and to ensure that learning is embedded, the Trust has commissioned an audit into the standard and accuracy of operation notes, as part of the monitoring of documentation audit programme overseen by the Trust's Health Records Advisory Group (HRAG). The completion of the audit, any actions arising from the audit and progress toward completion, will be monitored via HRAG as well as at bi-weekly divisional governance meetings and a monthly Executive Governance meeting.

We will also undertake a thematic review of past patient safety incident investigations where gaps and omissions in documentation and record-keeping were observed. Any identified themes and learning will be addressed through a quality improvement action plan.

Our PSIRF response plan will be updated to include a requirement for a review of the quality of documentation, and in particular the operation note, for all incident investigations that relate to complications of surgery.

Additionally, this case will be represented, with the context of your notice included, at the Trust's Clinical Audit meeting to remind clinicians of the importance of capturing key information related to surgery within the operation note. The presentation will take place in February 2025.

The case and this concern will be discussed at all our quality & safety huddles, serving as a reminder to clinical and nursing staff of the importance of the accuracy of record keeping and documentation.

Matter of Concern 2 – adequacy of investigations and learning from deaths

In response to this concern, we would like to illustrate the Trust's response under the Patient Safety Incident Response Framework (PSIRF) and explain the approach we took to applying our PSIRF Response Plan to the circumstances relating to the death of Mr Thompson. To aid with this please find enclosed a copy of our PSIRF Policy, which also includes our PSIRF Response Plan. You will be aware that the NHS guidance on responding proportionately to patient safety incidents was released in 2022, which the Trust has adopted as required. In line with this guidance, organisations are supported to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Organisations are directed to explore patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold.

PSIRF Response to the vascular bleed complication and subsequent emergency transfer out of the Trust.

Our PSIRF response began prior to Mr Thompson's death and immediately following the intraoperative vascular bleed that led to the post operative transfer out of Mr Thompson to the ITU department at University Hospitals Birmingham (UHB).

Patient safety incidents relating to emergency transfers were identified as a local priority in our PSIRF response plan (see section 7 of the enclosed PSIRF Response Plan). In accordance with this priority, and following discussion at our divisional governance meeting, a decision was made to commission a Multidisciplinary Team (MDT) Review. The method of investigation was chosen due to the involvement of several internal and external services (e.g. ROH theatres and anaesthetics departments as well as regional Acute Critical Care Co-ordination and Transfer Service ((ACCOTS) team and UHB ITU department) in responding to the vascular bleed and the subsequent transfer out.

A Multi Disciplinary Team (MDT) roundtable meeting was held with key representatives from internal and external stakeholders to discuss the surgical complications and identify any areas of learning and improvement. The MDT concluded that the vascular bleed was well managed and the emergency transfer out was appropriate and well handled. Minor learning recommendations were made to further improve the standard of our care in such circumstances, but no significant actions were needed as no gaps in care were identified.

PSIRF response to the cardiac arrest and subsequent death of Mr Thompson

Section 6 of our PSIRF response plan states that a PSII is required where a patient death is thought, more likely than not, to be attributed to potential problems in care. The PSII is therefore done to identify learning opportunities to prevent recurrence.

Following discussion at our divisional governance meeting, a PSII was commissioned. The terms of reference for the PSII related to the standard of our critical care response to the cardiac arrest and to whether there were signs or symptoms of deterioration that if acted upon sooner, could have prevented the arrest from occurring.

The PSII concluded that there were no obvious or significant signs of clinical deterioration or that the patient would have a cardiac arrest in the hours before the event. There was no evidence that a lack of care contributed to the cardiac arrest or that any actions could have prevented it. However, the investigation did identify aspects of the cardiac arrest management that could provide learning opportunities for future events.

PSII response to the conclusion of the Post Mortem report

Following receipt of the postmortem report, it was decided that no separate PSII into the cause of death was required based on our application of the PSIRF guidance issued by NHS England (NHSE). The risk of a peritoneal tear during such major complicated surgery is well known and the outcome, whilst rare, was a foreseen possibility and did not indicate there had been any surgical error.

Pursuant to this guidance, PSIRF and its supported activities (such as PSIIs), explicitly exclude and are insulated from activities that apportion blame, determine culpability, assess preventability, or identify the cause of death.

While we did not investigate the death further under PSIRF for the reasons given above, we did undertake a separate, additional review following the receipt of the postmortem report to assist with the coronial investigation. This process of investigation is explored further below.

Response to the coronial investigation and inquest

In response to disclosure requests received as part of the investigation and inquest process, we provided statements from key clinicians involved in the care and treatment of Mr Thompson. We also provided a copy of the PSII report.

The statement of [REDACTED], Consultant Orthopaedic Surgeon, was considered key evidence. It included a chronological summary of the surgery, detailing the vascular bleed, the transfer out and the peritoneal tear. The statement was informed by the postmortem report and included reflections on the significance of the peritoneal tear and the decision to repair it during surgery, in light of the cause of death.

Additionally, we conducted a further review in response to coronial enquiries relating to causation and of how the defect in the peritoneum likely occurred. This review also explored whether there were any signs or symptoms of the defect repair failing causing small bowel herniation before Mr Thompson collapsed. This review resulted in an additional statement authored by [REDACTED], Consultant Anaesthetist and Associate Medical Director, specifically addressing these points.

The review concluded that there were no specific signs or symptoms that would have indicated a defect in the peritoneum, or small bowel obstruction, that could have been secondary to the small bowel herniating through the defect.

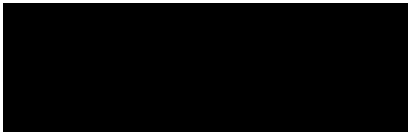
Identified Learning & Improvements

We have carefully considered the points raised in the Regulation 28 report and reflected on the Trust's implementation of PSIRF. The Trust acknowledges there are difficulties posed by the move away from Serious Incident (SI)/ Root Cause Analysis (RCA) reports. The Trust further acknowledges there is a need to ensure it provides sufficient information to satisfy its duty to assist the coroner with investigations. The Trust accepts that the overall presentation of our evidence did not provide a clear narrative, explaining the approach the Trust took to the investigation of Mr Thompson's death, the rationale and scope of the PSIRF investigations we undertook and the additional review we undertook based on the postmortem report and cause of death.

In order to better assist the coroner with future investigations and inquests, in addition to the standard disclosure of statements and copies of investigation reports, we propose to provide an overarching position statement. It is envisaged that the statement will summarise and explain our PSIRF response; the rationale and scope of our PSIRF investigations; the learning and actions arising from our PSIRF investigations; the outcome of reviews undertaken as part of our learning from deaths process; and any additional investigations undertaken as a result of postmortem reports and/or further requests from the coroner.

We would welcome the opportunity to further discuss this proposal should you feel it necessary to do so as the Trust seeks to ensure it is completely fulfilling its duty to assist the coroner in their investigations.

Yours sincerely



Interim Chief Executive