Mid and South Essex NHS Foundation Trust

H.M Area Coroner
Ms Sonia Hayes
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

Our Ref: [redacted]

[redacted]

6 February 2025

Dear Ms Hayes

Regulation 28 Report to Prevent Future Deaths – Thomas Burroughs

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) dated 12th December 2024, relating to the part-heard Inquest of Mr Thomas Burroughs.

We have considered your concerns and set out our formal response to each matter using your numbering as follows.

Matters of Concern

Incident reporting

(1) On 13 January 2024 acute Trust Hospital ward staff noted a split in the lumen of the Hickman Catheter and this was clamped and dressed.

(2) The incident was escalated for urgent medical review due to the significant risk of infection, however no Datix was raised for the split Hickman Catheter as required by the acute Trust protocol.

We acknowledge regrettably on this occasion there was a failure by staff to raise an incident when the event occurred on the trust's Datix incident reporting system (DCIQ) for the split Hickman line. A retrospective incident has since been reported with immediate learning identified and cascaded to all staff. We have also retrospectively reported the incident to the Medicines and Healthcare Products Regulatory Agency (MHRA). In events where implants or prosthesis has failed/malfunctioned or broken, the correct process is for the clinical team raise an incident and report it to the MHRA. Reflective learning has been taken by the individual staff involved, as well as the nursing staff from Edith Cavell Ward, and the wider medical and surgical wards.

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On 23 December 2024 and 29th January 2025 staff meetings were held on Edith Cavell Ward, (the location of the split Hickman line incident), to discuss Mr Burrough's experience in detail and identify learning opportunities. All staff were reminded of the Trust's expectations around incident reporting, and the requirement to complete their incident reporting training on the Trusts electronic training platform, 'Elevate'. Staff who were already compliant were directed to complete refresher training on incident reporting where required.

The Elevate training sessions focus on how to identify when an incident should be reported on DCIQ, and how to robustly complete the incident reports, with a focus on how to improve the quality of the record.

We are pleased to report that as of January 2025 Edith Cavell Ward has 100% compliance with incident reporting training. A recent audit of the Trust-wide position shows good compliance with this training, currently 89%.

Communication has been sent to all our inpatient adult wards raising awareness of what action should be taken if they identify a case of line fracture, and details of how to access our 'MSEPO-23026 Central venous access in adults' (CVAD) policy included for ease of reference. This policy provides detailed guidance for management of central venous access lines, and how to manage the line if issues arise. This is a current policy in place, accessible to all staff.

Each month we hold in-person Senior Leader's briefing sessions on all our acute hospital sites. The purpose of these briefings is to share key messages to senior colleagues, and the expectation is for these messages to be cascaded to all teams across all trust sites.

On 7 January 2025, our presentation referenced the anonymised detail of Mr Burrough's case, with a reminder that all staff have a duty to report incidents. It was emphasised that this includes where there is a near miss incident or no harm has been caused, and where all appropriate immediate actions have been taken.

Further, we specifically drew colleagues' attention to the fact that incident reporting includes but is not limited to all equipment failures or breakages, e.g., CVC line ruptures, which are reportable to Medicines and Healthcare products Regulatory Agency (MHRA).

In addition to this, the Patient Safety team issued an 'MSE Patient Safety update' during the week commencing 13th January 2024, highlighting the importance of reporting incidents, and our expectations on how the incident record should be managed.

Delay in removal of the Hickman line

(3) Mr Burroughs had a jejunal extension to his PEG on 15 January 2024. Advice was received that the Hickman Catheter should be removed as soon as possible if it was not being used.

(4) Mr Burroughs was tachycardic and spiked a temperature on 19 January 2024 with no apparent symptoms of recurrent aspiration and the Hickman Line remained in situ.

(5) The Hickman Catheter was surgically removed on 30 January 2024.

Our CVAD policy referred to above was in place at the time of Mr Burroughs' admission, which stipulates the necessity of vascular service input in the removal of indwelling lines.

I have not attached a full copy of the policy, however the guidance from section 5.15 of the MSEPO-23026 Central venous access in adults states:

'The removal of a cuffed CVAD/CVC (Hickman) or a Port/tunnelled haemodialysis line is a surgical procedure and is to be arranged with the vascular surgeons/renal team by the responsible clinician.
IF YOU THINK THE PORT IS INFECTED – OBTAIN BLOOD CULTURES and DO NOT DELAY ESCALATION - THIS SHOULD BE REMOVED WITH 24 HOURS BY THE ON CALL VASCULAR SURGEONS due to CRBSI.'

We are aware that as soon as the request for removal of Mr Burroughs' Hickman line was escalated to the vascular team at consultant level, the surgery was performed both urgently and safely.

We recognise that Mr Burroughs case identified non-adherence/awareness of the CVAD policy by clinicians across specialties, and specifically at the resident surgeon level. We have retrospectively raised an incident for the delay in removal of the line so that we can identify the issues and take the necessary action to avoid recurrence.

On 16 January 2025, the Clinical Director for Vascular Services, [redacted] presented Mr Burroughs' case to the vascular governance team meeting and discussed the need to remove in dwelling lines as soon as possible, (within the limitations of theatre access and emergency case prioritisation). Attention was drawn to the CVAD policy and the importance of compliance to ensure patient safety.

Communications have also been sent to all inpatient adult wards reminding staff to access the CVAD policy reiterating the importance of the timely removal of Hickman lines.

Further, it is our intention for the concerns raised in this PFDR report to be presented at the trust's next audit day which is attended by staff of all grades to raise awareness of the issues and maintain compliance.

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If I can assist further with these matters, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Chief Executive
Mid and South Essex NHS Foundation Trust