Mid and South Essex NHS Foundation Trust

H.M Assistant Coroner
Ms Rebecca Mundy
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

Our Ref: [redacted]

[redacted]

17 February 2025

Dear Ms Mundy

Regulation 28 Report to Prevent Future Deaths- William Hare

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) dated 20th December 2024, relating to the Inquest of Mr William Charles Hare (Bill).

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

Matters of Concern

Diagnostic stage

I. **There was an overall delay in reaching any diagnosis in Bill's case and, therefore, any treatment plan being implemented.**

II. **There was a delay in the first biopsy being taken which ultimately took place well outside the national guideline of 31 days.**

III. **There was a delay from the MDT referring the case to the Consultant, to an appointment taking place in May 2023.**

We have reflected on Mr Hare's experience and carefully considered how the patient pathway and treatment timescales could be improved.

We have made significant improvements to our diagnostic pathways including increased clinic capacity and designated consultant presence at all of our clinics. This is greatly reducing the diagnosis timescales for patients and improving overall patient experience.

We have improved the quality of care delivered at our pre-assessment clinics. Specialist staff are now reviewing clinic lists for patients such as Mr Hare, where HBA1c is poorly controlled and would benefit from early support from the hospital. We know that hospital led support yields the best outcomes for these patients, and so we have increased clinical capacity in this area. In doing so we monitor any deterioration of HBA1c control and work closely with our patients to counsel them on the impact this may have on the future treatments we can offer.

A further key development is the creation of a focused weekly kidney/upper tract urological cancers MDT (multi-disciplinary team) meeting. By separating this MDT from the general pelvic MDT, patients with suspected upper tract urological cancers are reviewed in a very timely manner and it is our routine practice to review all relevant patient scans taken within the past 7 days.

We are not experiencing any delays between scans and the MDT review and patient clinics to review results are happening, and within the timescale prescribed within the cancer pathway.

IV. There was an additional delay between the further CT scan ordered by the Consultant, which took place on 5 June, and the MDT which considered the results and treatment plan on 29 August, notwithstanding the fact that the MDT meet weekly, and Bill's case could have been considered at any of those meetings.

We now have one comprehensive patient tracking system for all hospital sites providing a centralised monitoring for all cancer patients and their progress through the cancer pathway.

The new system mitigates the risk of procedural errors and allows full visibility of patients' progress and treatment pathways across all hospital sites. Delays are minimised as the service can track diagnostic reporting.

Clinicians view their patient's status, including progress of any diagnostic procedures requested using the tracker, and any deviance from expected timescales or delays prompts action and encourages escalations to occur where required.

We are confident that scans are being reviewed by the MDT without delay. As explained above, we now have a specialist kidney/upper tract urological cancer MDT meeting held each week and the expectation of the group is that all relevant patients who had scans completed in the week before the meeting are discussed.

V. A further delay occurred from 4 September, as Bill had been assessed as unfit for surgery due to his HBA1c reading. Whilst this is unlikely to have been related to the cancer, there was likely to have been an opportunity, had his case been progressed earlier, at which his HBA1c was at an acceptable level for the procedure to be carried out.

My colleagues advise me that Mr Hare's HBA1c control was unfortunately in decline since his first presentation at the preassessment clinic on 4th September 2023. We cannot speculate that Mr Hare would have been a suitable candidate for the procedure at an earlier date as his HBA1c was never optimal for surgery and he was at high risk of complications including stroke. Poorly controlled HBA1c places patients at risk of death from such procedures and these risks were explained to Mr Hare when the clinical decision was that he was at too high a risk for surgery at that time. He was referred to his GP for HBA1c optimisation.
We have improved our pre-operative assessments and management of HBA1c to include consultant led support so that patients such as Mr Hare are identified as early as possible and offered in house endocrinology support to control their HBA1c.

Communication & transfer

VI. In his last admission to Basildon Hospital between November 2023 and January 2024 there were delays in progressing his treatment due to the disjointed nature of the inter-relationship between Basildon and Southend Hospitals as well as delays in transporting him to Southend Hospital which included failures to organise transport and properly coordinate his transfer.

We acknowledge that there were issues with inter hospital transfers and delays, however in this case transferring from Basildon to Southend had no bearing on the clinical outcome as Mr Hare was receiving appropriate care in Basildon HDU. However, we appreciate there should have been better communication at this time with the patient and his family. Should a patient require urgent transfer for specific treatment this is prioiritised by the Trust and the East of England ambulance service.

Radiology results

VII. A final delay occurred in the results of a CT scan, the results of which were not available until 15 January. By this time, the cancer had spread throughout Bill's body and became untreatable.

Our review of Mr Hare's records confirms the MRI and X-ray were completed as requested on 5th January 2024, however the CT scan was not carried out until 15th January.

Unfortunately, we believe this delay was contributed to by the junior doctor's strike that took place between 3rd January 2024 - 9th January 2024. The CT scan took place on the 15th January 2024 as this was the first available date once the service resumed normal practice.

On review of Mr Hare's MRI scan taken on 5th January 2024 and his clinical presentation at that time, regrettably the disease progression had made his condition inoperable, and surgery would not have been the appropriate treatment.

VIII. Among the delays, and potentially contributing to them, were a series of systemic and procedural errors largely related to processes controlled by isolated computer systems or people who are not medically trained. One example is the default of a referral or request to "routine".

Following the Inquest, we have investigated the concerns raised about the computer systems. I would like to assure you that we have not observed any issues as described at Inquest where requests are downgraded to routine when raised as urgent.

As explained in response to point IV above, we now have one comprehensive patient tracking system covering all hospital sites which provides centralised tracking for all cancer patients.

The new system mitigates the risk of procedural errors and clinicians can monitor the progress of diagnostic reporting, prompt appropriate action and encourage escalation where necessary.

IX. The lack of a specialist renal consultant at the MDT and lack of effective interaction between the people and systems at Southend and Basildon Hospitals prevented quick and effective decision making and, therefore, progress of Bill's diagnosis and treatment.

We are confident that these concerns have been addressed by the development of our kidney/upper tract urological cancer specific MDT meetings which take place following the general MDT each week.

The MDT's take place in a hybrid fashion (online and in person) and involve all three hospital sites. They are well attended by the teams including the specialist renal consultant, consultant surgeons, the lead anesthetist as well as our consultant physicians. The implementation of the new centralised system allows more effective team working across hospital sites and services.

Together with the improvements made to our pre assessment clinics we are identifying patients who require additional support with HBA1c at a much earlier stage and improving treatment options and outcomes.

We are currently undertaking a review of service demand and capacity for the MSE urology service with the objective to 'right size' the capacity in terms of workforce, equipment, and theatre lists. We are positive that this will support our ongoing improvements to patient pathways and experience in the future.

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

Yours sincerely

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Chief Executive
Mid and South Essex NHS Foundation Trust