Birmingham Women's and Children's
NHS Foundation Trust

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By Email Only
HM Senior Coroner
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5 March 2025

Dear Ms Hunt

Aarav Chopra – Regulation 28 : Report to Prevent Future Deaths

I write in response to your Regulation 28 Report issued to Birmingham Women's and Children's NHS Foundation Trust on 13 January 2025, following the inquest into the tragic death of Aarav Chopra.

We would like to express our sincere condolences to the family of Aarav, who have lost a very special child.

I have consulted a number of colleagues in order to respond to your matters of concern below;

Prophylactic antibiotics for severely immunocompromised patients*: The inquest heard evidence that patients like Aarav who are immunocompromised require additional prophylactic antibiotics for procedures. This is not covered in the current NICE guidelines. Your concern is that there is currently no guidance for the use of prophylactic antibiotics in severely immunocompromised patients.*
The Hepatology Team are in the process of reviewing the Trust's Liver Biopsy Guidance and are seeking the expert view of Microbiology colleagues to determine any evidence which suggests that immunocompromised patients need prophylactic antibiotics at a different time.

The Trust will respond to expert advice, literature and national guidance on this issue, noting that NICE and BNF guidance in context of certain types of surgery states that IV antibiotics should be given up to half an hour prior to any procedure even in immunosuppressed individuals. Currently,

there is no guidance to suggest prophylactic antibiotics should be giving any earlier than is current practice.

Experience and competence of trainees*: The inquest heard evidence that there was confusion around the experience and level of the trainee involved. He was thought to be an ST6 when he was an ST4. Your concern is that there is no mechanism to evidence trainees experience and competence when they travel to various different hospital trusts as part of their training.*

The resident doctors and fellows have a nominated clinical and/or educational supervisor who has an overview of the competence and support required. This information is then shared with the wider team through the local faculty meetings.

We will ensure that this process is strengthened further:

1. We will ensure that there is a formal record of all trainees and fellows attending the department at any given point in time.
2. We will ensure that the information on competence and support will be shared in the local faculty group meetings.
3. We will ensure that if the trainer is not the named Educational or Clinical Supervisor for the resident doctor, then there is a discussion between them to understand fully the competence and support required before any procedures or treatment.
4. The Chief Medical Officer has communicated with the consultant body in the recent Senior Medical and Dental Staff Committee meeting and has followed this up with an email.
5. The Director of Medical Education will monitor this through the Postgraduate Education Governance Structure.

Consent forms*: The parents of Aarav were unaware that a trainee would be doing the liver biopsy. Your concern is that there is currently no way to obtain consent when a trainee will be doing the procedure.*

GMC consent guidance states that patients and families should be given the right not to be involved where teaching, training or research is taking place. Therefore, families should be advised at the time of the procedure if a clinician in training may be performing the procedure. BWC will reinforce this GMC guidance to its consultant body in order to ensure the correct conversations are had between colleagues and importantly with our families. This information was shared in the recent Senior Medical and Dental Staff Committee meeting and has been followed up with an email to the consultant body.

Individual patient risk factors*: Aarav had a complex medical background and several risk factors for any procedure. Your concern is that there is currently no mechanism to identify individual patient's risk factors so that all clinicians involved in their care are aware.*

The importance of effective communication between colleagues will be reiterated across the workforce. In addition to this, the roll out of the Electronic Patient Record (EPR), which is due to go live in May 2025 will provide the ability to see at a glance individual patient risk factors.

Learning from deaths: *The initial M&M meeting after Aarav's death was described as inadequate. Your concern is that there was no immediate learning from this tragedy and further consideration is needed to ensure a safe and effective mechanism to properly learn from deaths at the earliest opportunity.*

The Trust's entire M&M process is currently under review. Terms of reference are being developed, and support has been requested from the lead at GOSH to assist with the reviews. Meetings with the Clinical Service and Governance Leads are in place over the coming weeks with 4 main specialities at the Trust's Children's site to review the current practice and identify areas for development. We expect this work to be complete by May 2025.

A weekly PSIRF Decision Team meeting was set up on 29 April 2024 and is chaired either by the Chief Medical Officer or Chief Nursing and Midwifery Officer. In attendance at these meetings are appropriate representatives from all Divisions within the Trust, who present specific incident categories and deaths where there might be questions raised about the care provided, identified through incident reporting structures and complaints.

Appropriate learning methodology within the PSIRF framework is agreed at this meeting with the oversight of the Chief Medical Officer or Chief Nursing and Midwifery Officer. This provides additional assurance of learning with respect to the learning from deaths. We recognise that in Aarav's case these review processes did not immediately capture the relevant learning which in part was owing to the transition to PSIRF methodology. As the organisation has adapted to PSIRF, the recognition of events requiring this method of investigation has strengthened.

In addition, governance practice within the Interventional Radiology Department is under review and will be amended to ensure that learning is achieved at the earliest opportunity.

Electronic patient records: *You heard evidence that the lack of electronic medical records meant clinicians found it difficult to see all of the patient's medication details. Your concern is that critical information can be missed if clinicians do not have access to all the clinical records when planning treatment.*

The Trust has procured an EPR which is due to go live in May 2025. It is anticipated that this will make all pertinent information available to staff at a glance.

In addition to the above concerns noted in your Regulation 28 Report to Prevent Future Deaths, I would like to address the issue concerning Aarav's antiplatelet medication, in line with your conclusion that "His death was contributed to by poor planning before the procedure when there was no consideration of stopping antiplatelet medication…"

The Liver Biopsy Protocol has been rewritten to include stopping antiplatelet medication prior to any surgical intervention.

Finally, I would like to reinforce the 12 action points from the internal investigation. I have detailed these below and indicated the progress of each recommendation.

Recommendation 1 (LP1) - When preadmission become aware that antiplatelet medications are being continued prior to a liver biopsy, there should be dissemination of this information as early as possible to both the operator and anaesthetist via the usual email process, and positive acknowledgement of this fact should be sought. Continuation of antiplatelet medication up to surgery should be the exception rather than the rule, but the final decision should sit with the operator. Complete

Recommendation 2 (LP2) - The threshold for the level of concerns to be discussed at the Sign Out should be lowered. Consideration should be given to rewording the Sign Out question for recovery, or adding a supplementary question to read *'Did anything outside the usual course of this procedure occur'.* Complete

Recommendation 3 (LP3) - The frequency of observations post-liver biopsy should be standardised. In progress

Recommendation 4 (LP3/4) - More comprehensive standard instructions for Recovery after intercostal approaches to liver biopsies (and other procedures carrying the same risk) should be developed. This should include the risks of occult (hidden) bleeding into the chest and focussed monitoring of the patient to recognise signs of early haemorrhagic shock. In progress

Recommendation 5 (LP4) - Enhance training should be provided for recovery staff to recognise the difference between emergence delirium and more serious reasons for agitation (as an addition to current training, plus simulation practice), together with guidance on seeking further opinion where there is any uncertainty. (Currently, recovery staff are PILS (Paediatric Intermediate Life Support) trained, however this does not cover surgical complications, so consideration needs to be given to a hybrid course covering such issues as recognising occult surgical haemorrhage). First part to lower threshold for concern complete, second part – hybrid training in progress

Recommendation 6 (LP5) - Develop and introduce a process to identify patients with a higher post-operative risk who would benefit from specific recovery review. Consider how to allow opportunities for post-operative Consultant Anaesthetic review within the Consultant Anaesthetic work pattern. It may be that the 'admin' Consultant Anaesthetist could perform this review if the designated anaesthetist was still busy in theatre. In progress

Recommendation 7 (LP6) - Reinstate a wider process of ward nurses reviewing patients in recovery with parents, with joint calculation of current PEWS score between recovery and ward nurses. This will improve more timely identification of patients in need of immediate medical attention and possible return to theatre. Complete

Recommendation 8 (LP7) - Implementation of a Trust-wide process or mechanism by which an emergency MDT can be convened where the appropriate senior specialists can discuss the most appropriate course of patient management. As a standard this should involve the primary team caring for a patient and any anaesthetic and surgical staff involved in any recent procedure. Such

an MDT could also involve other senior staff with relevant expertise as required. This new process/mechanism will need to be accompanied by wider education and expectations of communication in situations such as this. In progress

Recommendation 9 (LP8) - Disseminate learning about management of haemothorax from this case in trauma scenario training and by distribution of a 1-page summary of the incident and the learning points identified. In progress

Recommendation 10 (LP9) - Highlight the importance of detailed documentation of emergencies and ongoing resuscitation events across the Trust. Such documentation should include what happened and the rationale for management decisions made. This should be built into scenario training across the Trust and in the ED and PICU Medical Education programme. In progress

Recommendation 11 (LP9) - The Trust is introducing an electronic patient record system from next year which will mean that routine printing of data following emergency events on PICU will not be necessary. However, in the interim PICU should consider which other non-arrest resuscitation scenarios might benefit from post-event printing of data for the purpose of review and learning. In progress

Recommendation 12 (LP10) - PICU, Anaesthetic and Surgical consultants should work side by side in managing cases of significant surgical haemorrhage admitted to PICU (in a similar way to how they already do in cases of difficult airway management), to effectively harness the complementary skill sets of the specialties involved. In progress

I hope this letter assures you that the concerns you raised have been reviewed thoroughly and changes actioned where possible. I would like to reassure you that we have taken the learning from Aarav's death very seriously.

Yours sincerely

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Chief Medical Officer

On behalf of

[redacted]
Chief Executive Officer