NHS
Surrey and Sussex Healthcare
NHS Trust

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Dr Karen Henderson
H M Assistant Coroner for Surrey
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17th April 2025

Dear Dr Henderson,

Regulation 28 Report – response by Surrey & Sussex Healthcare NHS Trust
Inquest touching the death of Pamela Anne Marking (Date of Birth 20/09/1946)

This response comprises the formal response of Surrey & Sussex Healthcare NHS Trust (the Trust), pursuant to section 7(2) to schedule 5 of the Coroners and Justice Act 2009 and Regulation 29 Coroners (Investigations) Regulations 2013, to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 24 February 2025, made subsequent to the inquest into the death of Mrs Marking, which was concluded on 19 December 2024.

The Trust was given until 21 April 2025 to respond to the coroner, pursuant to Regulation 29(5) Coroners (Investigations) Regulations 2013.

We would like to start this response by offering our sincere condolences to Mrs Marking's family. As a Trust we are committed to learning from the issues raised during the Inquest.

The Prevention of Future Deaths report identifies a number of areas of concern, and we address these in turn in the following response, where it is within the Trust's ability to do so, and we describe the details of the actions that we have undertaken.

The term 'Physician Associate' is misleading to the public: Mrs Marking's son was under the mistaken belief that the Physician Associate was a doctor by this title in circumstances where no steps were taken by the Emergency Department or the Physician Associate to explain or clearly differentiate their role from that of medically qualified practitioners.

The term 'Physician Associate' is a national term, sanctioned by national bodies, and describes a particular group of healthcare professionals who have completed a recognised training programme. However, the Trust recognises that there is a lack of awareness amongst the public and indeed amongst some healthcare staff that Physician Associates are not medically qualified practitioners. Since we first employed Physician Associates (PAs) at the Trust we have tried to make this distinction as clear as possible. At the Trust, PAs always wear uniquely coloured

scrubs (turquoise), which are clearly embroidered on the front with “Physician Associate.” They also always wear distinct bright yellow lanyards clearly inscribed with “Physician Associate.” All the PAs are trained to introduce themselves to patients and their families as “Hello, my name is xxx, I’m a Physician Associate”. Subsequent to this Prevention of Future Deaths report, the Trust’s Chief Medical Officer and Chief Executive met with the Trust PAs and have instructed them to always introduce themselves as “Hello, my name is xxx, I’m a Physician Associate. I am not a Doctor, but a senior doctor will be overseeing your care.” This applies across the Trust, including in the Emergency Department (ED). Within the Emergency Department, since the Inquest, we have installed clear signage throughout, identifying the different members of the clinical team by the different colours of scrubs that they wear.

Lack of public understanding of the role of Physician Associate: Witnesses from the Trust gave evidence that a Physician Associate was clinically equivalent to a Tier 2 resident doctor without evidence to support this belief. This blurring of roles without public knowledge and understanding of the role of a Physician Associate has the potential to devalue and undermine public confidence in the medical profession whilst allowing Physician Associates to potentially undertake roles outside of their competency, thereby compromising patient safety.

The Trust has always followed national guidance regarding the scope of practice for Physician Associates. We recognise that PAs are not medically qualified, and we do not allow PAs to undertake roles outside of their competency, but they nonetheless have a valid role within the clinical team. Until February 2025 the Royal College of Emergency Medicine guidance was that in the Emergency Department Physician Associates should work on Tier 2 of the ED rota. That did not mean that PAs were the same as Tier 2 resident doctors, but that they could work alongside them. As of 28th February 2025, the Royal College of Emergency Medicine issued new guidance, stating that PAs should now be on Tier 1 of the ED rota. We immediately made that change and implemented the new guidance in full. We have issued a new scope of practice document for PAs in the ED which we have enclosed with this letter. This confirms that the Trust complies with the new guidance.

The right of patients and family to seek a second opinion: The lack of public knowledge that a Physician Associate is not medically qualified has the potential to hinder requests by patients and their relatives who would wish to seek an opinion from a medical practitioner. It also raises issues of informed consent and protection of patient rights if the public are not aware or have not been properly informed that they are being treated by a Physician Associate rather than a medically qualified doctor.

We believe that we have explained above all that is within the remit of the Trust regarding this concern.

Lack of national and local guidelines and regulation of the scope of practice for a Physician Associate: A diagnosis of epistaxis was made by the Physician Associate without appreciating the relevance of the vomiting and lower abdominal discomfort and in the absence of understanding the need to undertake palpation of the groins in an abdominal examination in a patient who was unable to give a proper clinical history because of short term memory loss. No evidence was presented that the management of Mrs Marking was subject to a reflective practice review. Given their limited training and in the absence of any national or local recognised hospital training for Physician Associates once appointed, this gives rise to a concern they are working outside of their capabilities.

The PA involved in Mrs Marking’s care has undertaken an extensive reflective practice review with a number of the ED Consultants and will include this in their annual appraisal.
We have had a local governance policy in place for all PAs that work at the Trust since 2015. Within this we worked to all available national guidance at the time and have amended the

policy in line with changes as they were made at a national level, particularly since the GMC began the process towards regulation.

The scope of practice for PAs at graduation is underpinned by the Department of Health Matrix of Core Clinical Conditions, enclosed with this letter, which outlines the key presentations and conditions that PAs are expected to manage. This framework ensures that PAs work within their competencies and escalate cases appropriately. At the time of Mrs Marking's death, the Trust was following interim standards for PAs and AAs (GMC) published October 2021 and the Core Capabilities Framework for Medical Associate Professionals published June 2022, enclosed. The following links to the NHS England guidance that contains all the relevant guidance that the Trust has adhered to since we first employed PAs: https://www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/

In response to the issues raised in this Inquest, and in response to the new guidance from the Royal College of Emergency Medicine, enclosed with this letter, we have issued a new scope of practice document for PAs in our ED and implemented it immediately, as of 3rd March 2025. This specifically states that if it is planned for a patient to be discharged from ED after seeing a PA, that patient must first be reviewed in person by a senior ED doctor, Tier 4 or 5. All our PAs and ED Consultants have been instructed to follow this change and are supportive of it and the document has been circulated.

Lack of guidelines for direct supervision and consideration of an appropriate level of autonomy for Physician Associates: Whilst there were discussions with the 'supervising' consultant the Physician Associate was effectively acting independently in the diagnosis, treatment, management and discharge of Mrs Marking without independent oversight by a medical practitioner. This gives rise to a concern that inadequate supervision or excessive delegation of undifferentiated patients in the Emergency Department to Physician Associates compromises patient safety.

The new scope of practice document addresses these concerns. PAs now work on Tier 1 of the ED rota. They do not now see undifferentiated patients, but have specific patients identified as suitable for them by an ED Consultant. Throughout the patient's stay within the ED, the PA will escalate to a senior ED doctor if there are any concerns or any deterioration in the clinical condition of the patient. Any patient seen by a PA who is for discharge will be reviewed face to face by a senior ED doctor prior to discharge. Any patient seen by a PA and then referred for admission will then be seen by doctor from the appropriate admitting speciality.

Lack of 'Updated' National Guidelines for Rapid Sequence Induction (RSI) of Anaesthesia for emergency surgery: Mrs Marking required a rapid sequence induction to protect her airway from aspiration of bowel contents as a consequence of small bowel obstruction. The consultant anaesthetist gave evidence that the 'traditional' use of consecutive syringes of induction agent and muscle relaxant was obsolete, and it was common practice locally and nationally to routinely undertake a RSI with Total Intravenous Anaesthesia, in the absence of updated local or national guidelines to support this practice.

There is national guidance that describes the use of modified Total Intravenous Anaesthesia during Rapid Sequence Induction, and it is accepted practice across the UK as an option. This guidance from the Association of Anaesthetists and the Society for Intravenous Anaesthesia is attached. The Difficult Airway society guidance lists it as 'accepted practice' in RSI. The traditional use of consecutive syringes of induction agent and muscle relaxant is still practiced by the majority of the clinicians in the anaesthetic department at the Trust.

Lack of 'Updated' National Guidelines to support the use of TIVA for RSI: Other than empirically increasing the rate of infusion of TIVA agents (Propofol and Remifentanil) no

evidence was forthcoming as to the target range required to ensure and confirm an adequate depth of anaesthesia for patients or the length of time required prior to and following the administration of a muscle relaxant (Rocuronium) to facilitate intubation. This is despite TIVA being known to provide a slower onset of anaesthesia and approximately 50% of all anaesthetic related deaths are due to aspiration (NAP 4).

At the Trust, if a clinician is using TIVA for RSI, they always use a modified TIVA technique which involves a predetermined dose of propofol as induction agent as a bolus and a predetermined dose of muscle relaxant as a bolus dose. This allows for rapid anaesthesia, as per the enclosed guideline.

Lack of 'Updated' Guidelines for use of Cricoid pressure and other measures to protect the airway in a RSI anaesthetic: Evidence was heard that as cricoid pressure was ineffective it was not routinely applied for a RSI intubation. After aspiration on Induction, the only suction device was attached to the nasogastric tube giving rise to a possible delay in timely suctioning of the feculent aspirate which was in excess of two litres after intubation was achieved.

The use of cricoid pressure during RSI is not universal in all situations as it can make intubation more difficult and is listed as an optional measure by the Difficult Airway Society. However, the Trust accepts that in the setting of bowel obstruction, with the increased risk of aspiration, cricoid pressure should have been used. This has been communicated across the whole anaesthetic team at a departmental meeting and in the Mortality & Morbidity meeting. All anaesthetic trainees at their departmental induction are instructed to use cricoid pressure and this is reiterated in regular simulation training.

We hope the above provides you with sufficient information and assurance but if you require more details, please do not hesitate to contact me.

Yours sincerely,

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Chief Medical Officer