Royal Berkshire
NHS Foundation Trust

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Sent via Email

16th July 2025

Dear Mrs. Connor

Thank you for your Regulation 28 report dated 23rd April 2025 concerning the death of Lorraine Parker who died on 30th April 2024. This Regulation 28 also referred to the deaths of [redacted] who died on 28th December 2023 and [redacted] who died on 4th March 2024. I would like to take this opportunity to express my deepest condolences to the families of Lorraine, [redacted] and [redacted]. The Royal Berkshire Foundation Trust (RBFT) is committed to learning from deaths and improving patient safety.

Please find below the trust's response in relation to the prevention of future deaths report addressing each point in turn.

1. **On the evidence I have seen from the three inquests referred to, the Royal Berkshire Hospital's death investigation process is not working well.**

The Trust Board is assured that learning from deaths is underpinned by a robust, structured process which includes compliance with a comprehensive formal policy outlining our approach to learning from deaths, including standardised reporting, investigation, and review processes, and engagement with bereaved families. Fostering a culture where staff feel comfortable raising concerns and sharing learning points has been very important to embed alongside implementing changes based on the learning from deaths process to improve patient safety and quality of care.

The attached appendix (Appendix 1) outlines how the different processes work within the Trust

It has been recognised through this inquest process that there are some specialties where there has been a need to support strengthened learning and we can report that this additional support has already been deployed. With regard to meaningful engagement in processes, and how informed discussions and identified learning are captured in clinical governance minutes, senior members of the Trust's Quality Governance Team have been attending surgery clinical governance meetings to support the learning and have seen evidence of adoption of Trust processes. These meetings, attended by senior surgical consultants, resident (trainee) doctors and other members of the multi-disciplinary team ensuring learning is cascaded throughout the team. Key learning has also been shared with other Specialty Clinical Governance Leads, the Mortality Surveillance Group and other key Trust committees.

2. **I have seen evidence of delayed morbidity and mortality meetings with no clear system for ensuring that these discussions happen timeously.**
3. **There is little (if any) record of areas of concern identified at meetings – whether at morbidity and mortality meetings or clinical governance meetings.**

Morbidity and mortality meetings are undertaken in each specialty where a death happens as part of specialty clinical governance processes. A systematic way for teams to capture learning is in place and set out below. The Trust also attaches Appendix 2, a set of forms to support the review process, designed to highlight any issues that may have arisen in care, together with a means of recording any recommendations and actions. This process is well established for specialties including intensive care and renal medicine and has been introduced into M&M meetings for general surgery from May 2025 with the learning captured within the clinical governance minutes. Specialty clinical governance minutes are disseminated to specialty team members by email as well as to the governance team and stored on a Trust shared drive where all specialty clinical governance minutes are held.

The specialty Clinical Governance leads undertake a development half day three times a year to support them in their role and Learning from Deaths and patient safety are regular agenda items. The concerns raised in this PFD, the learning, and actions being undertaken were disseminated at the most

recent workshop on June 18th, which included presentations and shared examples of how to have effective clinical governance meetings, and of good practice.

General Surgery has a clinical governance meeting 12 times a year. The current process for Morbidity and Mortality (M&M) is that the case is discussed in the month following the date of discharge from hospital or date of death e.g. if a death occurs in February, the objective is to discuss the death and any learning in the March meeting. All deaths, irrespective of cause, and/or whether there has been a significant complication, are discussed. If the operating surgeon is on leave or the case needs further information to inform discussion, the case is brought back to the next meeting; this can result in a delay in discussing a particular case. During these morbidity and mortality meetings the surgeons have a frank and detailed discussion to explore what happened and identify opportunities for learning.

The General Surgeons recognise their process for capturing the above M&M and care issues within their clinical governance minutes, has been very poor. Until April 2025, the governance minutes have been recorded by one of the administrative staff (i.e. not medically trained) without direction as to how or what to record into the minutes. Without explicit identification of learning points this has erroneously resulted in the record stating “no learning identified” even in situations where concerns were raised, learning points outlined and actions identified. In addition, the M&Ms have happened in such a timely way following a death that the opportunities to include the outcomes of a Structured Judgement Review (SJR) and/or Patient Safety Incident Review Framework (PSIRF) processes into the M&M discussion have been missed. It is recognised that there was no systemised process to bring back learning from SJRs, patient safety processes and inquests. We would wish HM Coroner to know that in the case of Mr ME, specifically highlighted by HM Coroner, that there was re-discussion in Clinical Governance following the SJR process. Clear learning points were identified and shared amongst the General Surgery department. We accept however that this was not adequately evidenced in our Clinical Governance meeting minutes.

The specialty is now using the M&M slides (Appendix 2) to capture learning and highlight areas of concerns. Examples are given in Appendix 3 of this. Any challenging areas requiring further discussion will be brought to the next consultant meeting to allow time for full exploration, and the learning brought back to the following governance for dissemination. The documenting and contemporaneous note-taking of these discussions will be by the consultant body. The M&M process within the speciality is currently being restructured to ensure learning points from Structured Judgement Reviews (SJRs)

and Patient Safety Incident Review Framework (PSIRF) processes are included in the presentations at the M&M meeting. Individual surgeons will be responsible for checking if any SJRs/Patient Safety Reviews are pending and updating the slides for presentation to the department at the formal M&M meeting. This will include learning points and any other points deemed salient and notable for sharing with the wider group.

The Trust acknowledges HM Coroner's concerns that some of these reflections and notes of discussions are not provided timeously to the coroner. The Trust confirms the notes of these discussions will be stored on shared clinical governance drive and the Trust will provide access to the Legal Services Team to these notes so that in future they are available when disclosing medical records to the court. To assist with this, we are developing a checklist of items which may be required for inquests, along with how to locate them on the Trust's systems.

The Trust recognises there is a need for greater clarity of learning and actions undertaken for a case especially where there have been multiple types of review. Our intention is to provide a summary overview of the case with the notes disclosure **(**Appendix 4). This will include a brief factual timeline of the patient's clinical journey, key diagnoses and treatment and circumstances of deterioration and death. The next section will include the Trust reviews undertaken, each with a concise summary of learning points, and outline of actions taken by the Trust including communications with the family. The Trust will identify any concerns around avoidability and preventability. The Trust will be clear whether all reviews are now complete and if any are ongoing. The latter recognises that additional reviews are on occasion indicated if new learning or information becomes available.

4. There is delayed escalation of concerns.

General Surgery has appointed a departmental mortality lead and a patient safety lead, in addition to the current Clinical Governance lead. As well as their role within the department, these clinical roles will allow specific surgical attendance at Trust Mortality Surveillance and Patient Safety Committees. The consultants will all keep a contemporaneous record of data relating to bariatric and colorectal resections and from this data will have quarterly presentations of key performance indicators relating to each subspecialty. This will allow earlier oversight of significant complications for a particular operation or a particular surgeon. As with all concerns, the Trust has an open culture policy, that should another member of staff have any concerns regarding performance or conduct, they can raise

it, confidentially with their Clinical Lead, Clinical Director or Care Group Director; or indeed through the Trust Freedom to Speak Up processes.

5. Structured judgement reviews I have reviewed are at best, poor, and at worst, defensive.

There is a systemised process in place for Structured Judgement Reviews to be undertaken within the Trust. Each specialty is notified when an SJR is to be undertaken with and is responsible for allocation of the SJR and its subsequent completion. This is undertaken by a consultant who has not been involved in the patient's care.

The mortality team were aware that the SJR 1s for ME and MR both done by upper GI surgeons and not the colorectal surgeons, were not sufficiently thorough or enough of a considered review by general surgery. The completion did not meet the standard expected in relation to this process.

However, for MR, given the wider trust investigation and the detailed statements that were being compiled for the inquest we did not undertake to repeat the SJR as this more detailed review superseded the SJR process. This was something given careful thought to in how we could maximise our learning about this gentleman's care, not least for his family. For ME an SJR 2 was undertaken, and significant learning was identified. Intentionally this was done by the Director for Planned Care who is a gastroenterologist and experienced endoscopist and not by the surgical team, given the central relevance of the discrepancy between CT and endoscopic localization of the tumour and the issues related to tattooing. For LP, following immediate Medical Examiner scrutiny, an SJR was not requested as the cause of death was not known and a referral was made to the Coroner. Following the Coronial post-mortem, with the finding of Medical Cause of Death 1a as pulmonary embolism, the case was progressed, as per Trust due process, to the VTE Committee for further review with learning identified and documented. This was highlighted during the inquest. This learning was taken back though General Surgery clinical governance as part of good practice.

Engagement with Learning from Deaths, including the SJR process is, in the main, very good across the Trust and is an important learning process and debrief for our healthcare teams, as well as the opportunity to engage with the deceased next of kin within that process. It is recognised that this can sometimes vary between teams and individuals and we work increasingly closely with those who may require additional support to adopt this valuable way of working and learning.

General surgery have made changes to how structured judgement reviews are performed. Historically, cases were allocated to an individual GI surgeon, who may not have had the same subspecialist interest (e.g. colorectal surgery, upper GI surgery, and bariatric surgery) as the particular case being examined. It has been agreed that moving forward the SJR will be performed by a person with the same subspecialist interest, with and then reviewed by a second surgeon, preferably from outside that subspecialty. Both surgeons will sign off on this and have their name attached to the report. This subspecialty engagement and sense checking of reviews should provide a robust approach with more thoughtful outcomes. We have also introduced a parallel anaesthetist led SJR to strengthen the review and identify learning, in recognition of the different perspectives that surgeons and anaesthetists can bring to the same case.

Our mortality surveillance committee where individual cases are reviewed is extremely well attended with robust discussion about the quality of care provided.

6. **Delayed or no scrutiny of cases being reported to the coroner because the cause of death is unnatural, given that medical examiners are not funded to scrutinise those cases. Opportunities for early learning are therefore being lost.**

The Medical Examiner Service, a national system in England and Wales, focuses on providing independent scrutiny of deaths that are not investigated by a coroner.

Despite this, and of particular note, in all 3 cases that this PFD is in relation to, there was timely and proportionate scrutiny by a Medical Examiner. This supported timely referral to the Coroner, with two cases identified by the Medical Examiner as needing further review by the Trust in the form of a SJR. The third case was notified to the Coroner due to an unknown cause of death. A Coroner post-mortem was subsequently undertaken with the finding of MCCD 1a as pulmonary embolus. The appropriate Trust process was followed for this case with review by the VTE Committee with opportunities for learning identified through Medical Examiner scrutiny.

The Trust Medical Examiner service works to national standards and undergoes quality assurance in relation to its ongoing performance through data collection, benchmarking and National ME and Regional ME visits (2024 and 2025 respectively). Quality control of SJR requests by the Medical Examiner is undertaken on an annual basis and reported to the Trust Quality Governance Committee.

Trust Medical examiners offer support with complex cases, and ensure that deaths meeting the criteria for Coroner notification are promptly and accurately referred. Their scrutiny helps identify any concerns that may require further investigation. Learning from deaths is reported into Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS) and Frimley ICS.

7. **Systems of collating and providing medical records and clinical governance records to the coroner (and presumably to others involved in death investigation) are unreliable.**

The Legal Services Department acknowledge the Coroner's comments with regards to records and other disclosure, and apologise for recent cases where this has fallen below the expected standard. It would be beneficial to learn from the Coroner what format is required in disclosure i.e. whether chronologically ordered records or records ordered by document type would be preferable. The head of legal services has reached out to the Coroner/Coroner's Officers regarding this and is awaiting a response

The Legal Services Department are in the process of reviewing how we collate and provide medical records and clinical governance records to the Coroner. A number of new steps will be implemented which are as follows:

a. Inquest disclosure checklist

   The department are in the process of implementing a disclosure checklist which includes an outline of what has been requested by the Coroner's Officer and what has been disclosed. The checklist will be required on every request by the Coroner, and will act as a "Front Page" of the inquest file so that it what has been disclosed to the Coroner is clear to the file handler. The checklist will require team members to complete sections outlining what has been requested, what is available, and what has been disclosed including the dates of these. Patient Safety incidents, Structured Judgement Reviews, and Clinical Governance/Mortality and Morbidity documentation will also be obtained as a part of this checklist. There will also be 28 day checks and 14 day checks, which will take place at the respective points before an

inquest. This will ensure that the file is checked prior to the inquest, to give assurances that the Coroner has been provided with all the required disclosure prior to the inquest.

b. Formatting of records disclosed

The department are also in the process of updating the format of medical records bundles when disclosing to the Coroner and other external parties. Medical records bundles are downloaded from the Electronic Patient Records (EPR) system in chronological order insofar as is possible. Some scanned documents are uploaded to the EPR in bulk and therefore not at the time of writing. These appear in the chronological order as the date they were uploaded onto EPR rather than the date on the individual documents. Records from other systems such as MediSight (Opthalmology), ARIA (Chemotherapy), and ICCA (Intensive Care) will also be downloaded and requested. These records will feature under their own sections within the medical records bundle. Any paper records predating the EPR system will also feature under their own section. The bundle will be organised with an index page, clear sections denoting which system records are included, and pagination to include page numbers and cover pages for each section.

8. I am concerned about whether the trust has done enough to deal with the concerns about this particular surgeon, not just in the Berkshire area, but more widely.

Matters pertaining to the individual surgeon are of a sensitive and confidential nature and generally subject to data protection principles, however, we will summarise the actions taken by the Trust with respect to the identified concerns about this surgeon's practice. Further information can be made available to Ms. Connor in confidence.

When the concern regarding a potential increased complication rate came to light an in-depth local audit of practice was undertaken by the Trust. This did indeed identify that the surgeon had a higher complication rate than his peers. Following this, a mutual decision was taken to limit the surgeon's scope of practice whilst a further investigation was conducted. This investigation was conducted in line with the Trust's "Maintaining High Professional Standards (MHPS)" policy and encompassed four

Terms of Reference including the excess complication rate. The process undertaken to first conduct a "fact finding" exercise followed by a full MHPS investigation follows the national MHPS framework; as does maintaining the restriction to practice to the minimum possible to ensure safe practice.

The MHPS investigation was undertaken by a trained, external, independent investigator and found evidence to uphold all four Terms of Reference and proceeded to a formal hearing. At this hearing an appropriate sanction was handed down which remains on the surgeon's record and an Action Plan for remediation was also instigated.

Should the surgeon choose to return to full scope of practice, a further assessment by the Practitioner Performance Advice Service (PPAS), a branch of NHS Resolution specifically established to assist Trusts in managing and resolving practitioner concerns, and a period of retraining will be required.

Throughout this process both the General Medical Council (GMC) and PPAS have been consulted with and kept informed. The surgeon was first referred to the GMC in 2019 by the wife of a deceased patient following an earlier case. After a provisional enquiry they undertook a full investigation, which was protracted due to the covid pandemic. This concluded with a Fitness to Practice hearing with the MPTS in early 2024. Their decision was to offer a sanction to the surgeon, which was accepted by him. It should be noted that this sanction was related to medical indemnity and not to the surgeon's clinical practice.

Following the clinical negligence case against the surgeon and the private healthcare provider where he worked, which was bought by the wife of the deceased and heard in June 2024; the Trust's Responsible Officer (RO) contacted the GMC and enquired whether this would alter their previous ruling on the case. They re-opened the case via a Rule 12 which enables them to re-examine a case if new information has come to light. The Trust was recently notified that the GMC had upheld their original ruling and there was no further action required.

In parallel to this, since the original case, the Trust has been discussing the surgeon extensively with its GMC Employee Liaison Advisor (ELA). The ELA service provides a forum for informal discussion and advice between the GMC and the Trust RO and/or Chief Medical Officer. Our ELA is fully informed of the situation and the restricted scope of practice of the surgeon concerned. A copy of the final MHPS Investigation report was submitted to the ELA and she was assured by the actions that the Trust had taken as an organisation.

Similarly, PPAS provide the Trust with a Liaison Officer; and she has also been available for advice and guidance in managing the practitioner throughout. Finally, as is standard practice, as soon as a

restriction to practice was agreed with the surgeon, the Trust RO made contact with the RO at the local private hospital that the surgeon was also practising at. As far as the Trust is aware, similar restrictions to the surgeon's scope of practice were implemented there too and the RO is being kept informed of the Trust's investigation and processes. To the Trust's knowledge the surgeon does not undertake medical practice at any other providers.

The Trust continues to keep matters under review and continues to manage this surgeon within the parameters of the relevant processes and procedures.

In light of the Trust's duty to protect employee data, regarding information contained within this response, where it needs to be shared with third parties, the Trust respectfully requests for this to be in compliance with the relevant data protection principles.

In summary the steps taken by the Trust in order to escalate concerns in the Berkshire area were to assist the GMC, undertake an internal review, remove the surgeon from various high risk procedures, work with the GMC Employment Liaison Advisor and also liaise with the two private hospital networks in the area to highlight steps taken so they could make an informed decision as to what steps they needed to take in regard to the surgeon's practicing privileges. The Trust considers it has taken all necessary, proportionate and reasonable steps to escalate and manage concerns in regard to this surgeon.

The Trust also considers it took swift action once a pattern of issues had arisen. The relevant dates are:

ME initial Operation 21.11.23, with date of death 28.12.23

LP initial operation 23.01.24; with date of death 13.03.24

MR initial operation 13.02.24; with date of death 04.03.24.

As can be seen, there is a period of just over 2 months between the deaths. Following the death of LP, discussions were had with the surgeon and the Trust requested he take a period of absence to reflect on his practice. It was upon his return a formal investigation was undertaken and restrictions on practice provided. The Trust considers for this level of investigation to be commenced, a pattern needs to be established. In this surgeon's case, there was no pattern established until the death of LP, following which the Trust took action to limit patient facing care.

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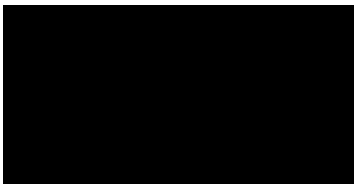
I trust this has provided the required assurance in relation to the changes that are being implemented within the speciality and within the internal legal processes in order to improve patient safety. Please do not hesitate to contact me should you need any further information

Yours sincerely



Chief Executive Officer