Tameside and Glossop
Integrated Care
NHS Foundation Trust

[redacted]
Chief Executive Officer
Tameside and Glossop Integrated Care NHS Foundation Trust
Silver Springs
Fountain Street
Ashton under Lyne
Lancashire OL6 9RW

11th August 2025

FAO Mr Morris

HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
Cheshire
SK1 3AG

Dear Mr Morris

Reference: [redacted]

I am writing further to the inquest regarding the death Lila Marsland (who died on 28th December 2023) which concluded on 6th June 2025 and the subsequent Regulation 28 Notice issued to the Trust. I hope to set out below my response in terms of what we are already doing and what we plan to do in relation to your concerns.

Concern 1 - notwithstanding the work the Trust has undertaken in response to Lila's death, the Child Sepsis Screening Tool is not yet fully embedded in the minds of those who assess and treat Children and Young People at the Trust

I would like to take you through and reinforce some of the key improvement works the Trust is undertaking to ensure that the Sepsis Screening Tool is fully embedded in the mind of those who assess and treat children and young people.

The Trust have implemented regular audits for PEWS and sepsis. Since February 2025 this has converted to daily audits. The results of these audits are shared on safety huddles and immediate actions taken. The Paediatric ED Matron reviews the audits weekly, sends action emails if themes appear and if there is any individual learning identified there will be further training provided by the Paediatric ED Matron and the Practice Based Educators (PBE).

The Paediatric Matron has also devised individual sepsis and PEWs action plans which monitor the calculation of PEWS scores, observations and escalations. These results are shared monthly at the Sepsis and Deteriorating Patient Program Board which is chaired by the Deputy Medical Director. The Trust also has in place a Trust wide Sepsis Action Plan led by the ED Matron and ED Consultant. This Trust wide Action Plan is also discussed and has oversight at the monthly Sepsis and Deteriorating Patient Program Board.

From August 2025 onwards, the Trust will be incorporating audits as additional standards to the Quality Assurance Rounds (QAR) conducted each month. This will allow for greater oversight of audit results and make it easier to analyse the data. The audit outcomes will help identify clinical improvement opportunities and will also be used for feedback to division and governance meetings. The data gathered each month will be reviewed the following month. To support this change, the Quality and Patient Experience Team arranged a series of rollout education sessions for Ward Mangers and Matrons throughout July/August 2025.

The Trust now has a co-mentoring audit completed by a senior nurse (Band 6 or above) who reviews all attendances to ED to check nothing has been missed regarding safeguarding/referrals. The Matron has oversight of this process and is emailed every morning with a summary of findings. Again, if themes are identified, the Matron, Nurse and clinician will be emailed. If some patients have left without being seen, an incident will be raised and managed through the Trusts' governance processes. Weekly documentation audits have been commenced since March 2025, with a focus on all aspects of nursing documentation. Themes are collated weekly and shared with the team on the safety huddle and individually for those staff members who require further support or training. Practice Based Educators have also commenced training with the new starters around documentation and the importance of accurate record keeping.

There has been a redesign to the electronic triage form so that you cannot bypass the sepsis screening questions. The ED Matron has worked closely with system developers to create an e-Card Triage System with mandated sepsis screening which forms part of the sepsis bundle. The Manchester Triage System (MTS) is in place. All triage practitioners are registered on the MTS system and annual triage audits of all triage practitioners are in place (this is on-going). Triage training is a rolling programme throughout the year, ensuring any triage practitioners who require further support or training have the opportunity to access the programme supported and delivered by the triage train the trainers and practice-based educators.

There has, in addition to the existing Practice Based Educators, been a recent recruitment drive where the Trust have successfully recruited two further Practice Based Educators to help deliver training and learning across the organisation and they will commence in their roles in November/December 2025.

Sepsis simulations (SIM) are delivered monthly the latest being in July 2025. Focus weeks have been held in April 2024 and September 2024 for both adults and paediatric ED, in addition to a sepsis focus week in March 2025. Throughout the week commencing 14th July 2025 there was an additional sepsis focus week aimed at all walk-in patients and there will be a further sepsis focus week commencing 15th September 2025 as it is World Sepsis Day on 13th September 2025.

The Trust now have in post a simulation co-ordinator who helps to arrange and facilitate all the organisations SIMs teaching across both adults and children's emergency departments. Since 29th January 2025, the Trusts has facilitated 24 different simulation sessions and 17 of these have had sepsis as a primary or secondary learning outcome and there have been 181 participants over this period of time. One in four simulations is now Children and Young Person specific.

The purpose of the SIM is to use members of staff in their own roles (F2s, clinical fellows, middles grades, consultants and nurses) to allow the Lead Consultant to identify how confident staff members are in their roles and observing how they manage an unwell child in the realistic clinical space. It is also an opportunity to identify good areas of practice and learning resulting in the simulations being an invaluable teaching aid. Sepsis SIMs are performed on a monthly basis for both adult and paediatric ED but simulation training is carried out every Wednesday which cover various topics and themes including but not limited to; Silver Trauma with urosepsis, cardiac arrest/Hyperkalaemia and Respiratory failure. A simulation training session was conducted on 30th April 2025 specifically for meningitis covering A to E assessment, treatment of meningitis and the causes and risk factors.

The learning outcomes from the simulations can lead to actual changes in practice/procedure.

Examples of this are:

1. We now have a white board in the Paediatric Resus Department which enables us to make important notes during a resuscitation

2. We now have a WETFLAG chart on the wall in Resus - this enables clinicians to prepare emergency drug doses for resuscitation more quickly

3. All North West Transport Service (NWTS) guidelines are printed and kept in the Paediatric resus area for easy and quick access/reference

4. Specific training for Intraosseous (IO) insertion has been given to doctors in ED

5. We have regular resus trolley checks and a safety checklist

On 4 December 2024, the CQC commenced a responsive assessment of the services for children and young people because of concerns around child death incidents. They carried out an unannounced inspection during 28 to 30 January 2025.

During the inspection, the CQC spoke with 10 parents and young people who used the service and looked at 18 care records. They also spoke with staff, leaders and service partners and looked at policies and other documents relating to the service.

The assessment report was published on 6 June 2025 and is publicly available on the CQC's website. The overall rating for services for children and young people stayed the same - the service was rated as good. A rating of good was awarded in all domains (safe, effective, caring, responsive and well led). The report covers some of the pieces of work the Trust has already highlighted above.

In brief, the report states:

- The service had made improvements to processes for managing deteriorating health and sepsis management and had plans in place to make further improvement.

- The service had made significant improvements around staff training and processes for managing deteriorating health and sepsis management following child deaths during 2023. Action plans were in place to further improve this.

- The service had guidelines, pathways and screening tools that were based on national guidelines for the management of children and young people with sepsis, including neonatal sepsis. Staff understood how to identify and manage sepsis in line with policies and national guidelines.

- Training in aspects of sepsis management was included in paediatric life support training and paediatric acute illness management courses undertaken by staff. Additional in-house paediatric sepsis training had been developed and was planned for roll out during March 2025.

- Staff in the children and young people's emergency department participated in regular sepsis simulation activities. These involved multi-disciplinary teams managing scenarios to develop skills and identify learning. A number of doctors and advanced clinical practitioners had also been trained as sepsis fellows, who worked with clinical teams to champion learning and improvement.

- A children and young people's sepsis audit was undertaken during August to September 2024, following a previous audit in May 2024. The audit was based on 7 indicators and showed improved compliance in 5 audit indicators since May 2024. These were for taking blood cultures, administering IV fluids within 1 hour, use of sepsis screening tools, implementing sepsis care bundles and completing full set of observations on admission. The audit showed further improvement was still required in 2 audit indicators; antibiotics prescribed within 1 hour of suspected sepsis and full set of observations undertaken at triage.

- The emergency department also undertook a separate monthly sepsis audit, based on 10 random adult and children's records. This showed an improving trend in compliance between April 2024 and December 2024.

- A sepsis action plan was in place to improve processes. This included actions planned or undertaken relating to continued audit and monitoring of compliance, further staff training and raised awareness through shared learning.

I consider the above evidence demonstrates that the Trust is providing training for sepsis, identifying learning and implementing these changes effectively and validates that the Trust is ensuring that sepsis is embedded in the minds of those who assess and treat children and young people.

The Trusts' work around sepsis continues and there is no intention for any of this to cease in the immediate future.

<u>Concern 2</u> - Trust is yet to fully implement the latest iteration of the National Institute of Health and Care Excellence's Guideline Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management (NG240 Published 19 March 2024)

The National Institute of Health and Care Excellence's Guideline Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management has been implemented and

that Trusts' meningitis guideline has been updated in line with NICE. The Trust has prepared and shared a seven-minute briefing reaffirming the subtle signs of meningitis which was distributed to all staff (consultants, trainees etc.) by email on 5th February 2025 and has also been shared at Clinical Paediatric Governance meeting on 13th February 2025.

A meningitis audit was conducted in January 2024 to review those instances where we weren't meeting the guidance. That audit did not highlight any missed cases.

In February 2024, the Trust undertook a proactive investigation into child deaths. The results of this investigation were shared with the Care Quality Commission (CQC), and the Trust responded to associated information requests in May and July 2024.

As mentioned above, on 4 December 2024, the CQC commenced a responsive assessment of the services for children and young people because of concerns around child death incidents. They carried out an unannounced inspection during 28 to 30 January 2025.

The report also identified the below additional learning around meningitis:

- The service completed an audit in November 2024 to assess staff compliance with NICE's recommendations for 'meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management (NG240)'. The audit identified good staff compliance in standards around initial assessment, taking blood cultures and blood sugars, undertaking correct investigations and computed tomography (CT) scans and antibiotic choice and duration.

- The audit also identified areas for improvement in some standards such as taking throat swabs, commencing IV antibiotics within 1 hour of meningitis being suspected and post-discharge follow-ups for bacterial meningitis. The service had developed action plans and guidelines and policies for staff to aid learning and improvement.

<u>Concern 3</u> - The Locum Consultant in Emergency Medicine who completed a form indicating Lila was 'Safe to Transfer' to the Paediatric Emergency Department did so without undertaking any examination or direct assessment of her. The doctor had previously filed a statement at court indicating he had undertaken a 'preliminary visual assessment' of Lila, but accepted in oral evidence that this was not, in fact, the case

The Trust has changed its 'Safe to Transfer' process in ED. The Children and Young Person ED has moved into the same footprint as the main ED department as of July 2024. This means that if a child is screened positive for sepsis at triaged, the triage nurse would go to a senior clinician in ED and be commenced immediately on the sepsis bundle. That patient would be streamed to a cubicle for immediate review by a doctor. All the care is given in the emergency department and only if required to transfer to paediatrics for admission would an SBAR be required. If too unwell, Paediatrics would come to ED. The form that the doctor signed in December 2023 is no longer required. The transfer form used for Lila is no longer in use.

The Trust has spoken to the doctor concerned who has reflected on his practice and the implications of the statement of truth he signed. This doctor is under the Trusts' internal HR

review process. The Trusts' Responsible Officer has been engaging with the relevant governing bodies throughout their review process which remains on-going.

Since the inquest, further training has been delivered by the Trusts' panel firm at Grand Rounds on 25th June 2025 on statement writing including the implications of the statement of truth. Grand Rounds is an open attendance to all medical professionals from Health Care Assistants to Consultants and is delivered every Wednesday and includes a variety of teaching topics and learning for staff.

Legal Services are also hosting a Legal Conference on 2nd September 2025 and statement writing is an agenda item.

<u>Concern 4</u> - No medical record appears to exist of the examination of Lila which was undertaken by the Locum Registrar in Paediatrics which resulted in discharged from hospital. The absence of this key piece of evidence serves to limit the ability of the Trust to derive all possible learning from Lila's death

The locum registrar has discussed her evidence with the Trust solicitor for Tameside and Glossop Integrated Care NHS Foundation Trust as well as the doctor's current responsible officer at her current organisation. She too has reflected on her own practice and understands the omission she made in relation to her documentation, something which she has insisted will not form part of her future practice.

The importance of documentation is revisited at the Trust on a regular basis at the bi-monthly Medicine and Urgent Care Divisional Meeting as well as the Surgery, Women's and Children's Divisional Meeting. Legal Services also contribute to these meetings in relation to the learning from inquests and it is an area the Trust are continuing to monitor and develop.

In terms of investigations, the Trust moved to the Patient Safety Incident Response Framework (PSIRF) in May 2024. This sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This process replaced the previous Serious Incident Framework (2015). The comprehensive investigation for Lila came under the Serious Incident Framework.

Under the Patient Safety Incident Response Framework (PSIRF) there is now a greater emphasis on engaging with those affected by the incident including patients, families and staff. Ensuring they are treated with compassion and be able to be part of the investigation. This was not something that occurred routinely as part of the Serious Incident Framework. This allows families and patients to share their perspectives and will formulate part of the investigation/learning response. This new collaborative approach ensures that it is not solely a paper exercise or review of a patients' medical records based on the view of the Trust but that it assists in providing focused terms of reference so that areas of concern can be reviewed and allows the organisation to evidence the learning that has and will take place following the patient safety incident.

On behalf of the Trust, I want to express my sincere condolences to Lila's family for their loss.

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I hope this response has provided assurance that the Trust has taken your comments and concerns seriously and action taken to minimise the risk of such an event occurring again. Should you require any further information, please to not hesitate to contact me through the Legal Services Team on 0161 922 5020.

Yours sincerely,

[redacted]

[redacted]
Medical Director
On behalf of [redacted] (Chief Executive Officer)
Tameside and Glossop Integrated Care NHS Foundation Trust