York and Scarborough
Teaching Hospitals
NHS Foundation Trust
Chief Executive Office
York Hospital
Wigginton Road
York
YO31 8HE
Andre Bertram, Interim Chief Executive
[redacted]

Ms C Cundy
HM Area Coroner for North Yorkshire & York
[redacted]

Dear Madam

Thank you for raising your concerns following the inquest surrounding the death of Pamela Honeybone regarding her admission to Scarborough Hospital in September 2024. York & Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) recognises the seriousness of your concerns outlined at Section 5 of the Report to Prevent Future Deaths (PFD). I write to outline the actions we have taken to address these. These measures are intended to reduce the risk of recurrence and improve the quality and safety of care provided to our service users.

On review of your concerns, we have grouped these into four areas for response.

1. **Nonadherence to the Patient Identification process**

The Trust has an Identification of Patients policy in place. This has recently been reviewed and findings from this case have been used to strengthen adherence to the identification process.

In addition, it is reassuring to note, in relation to the audit results presented at inquest by Matron [redacted], there has been a significant improvement in positive patient identification in more recent audits following Trust wide communication reminding staff of the importance of positive patient identification. This policy is also subject to regular audit to confirm compliance.

2. Radiology transfer checklists not in place across the Trust

The action in the Patient Safety Incident Investigation (PSII) report to standardise the radiology transfer checklist is almost complete. It was acknowledged that the CT transfer checklist in place at the time of Mrs Honeybone's admission was not robust and not in place across the Trust. It was agreed that a transfer checklist was needed for all radiological investigations, not just CT scans. The checklist has been drafted and reviewed in consultation with the wider Radiology and nursing team and a final draft is awaiting sign off at the Radiology Governance Board. The checklist is due to be published and deployed for use at the end of November 2025.

Radiographers will be empowered to decline investigations if the checklist is not complete. This will be monitored at the Radiology clinical governance meetings and escalated to the Cancer Specialist & Support Services Care Group Board.

3. Identification of radiological error not immediately conveyed to the treating team

When a potential identification error is identified it is usual to report this on the Datix incident system. Initial investigations then take place to establish whether an error has occurred. Once an error is confirmed the treating clinician is advised of this and asked to consider any harm attached to the error and notify the patient of this in line with our Duty of Candour obligations. This process can take some time, but it is preferable for the initial investigation to be concluded before the findings are conveyed to a patient. We do however acknowledge that in this case this meant the treating team were not aware of the incorrectly attributed images prior to Mrs Honeybone's death and this resulted in a delay in referring the death to HM Coroner.

Going forward, where a discrepancy is identified, this will be reported via Datix ideally within 24 hours. Incidents are reviewed daily by Care Group governance teams and therefore can ensure the relevant clinical team will be made aware of a potential issue within 24hrs during the working week and 72hrs, at worst, over the weekend period. This will alert to the need for multidisciplinary discussion and investigation.

All reporting teams will be reminded regularly at Radiology meetings, and discrepancy meetings, of the need to initiate this Datix when they are aware of any confirmed patient identification errors discovered during reporting. However, implementation of the transfer checklist will improve compliance with the patient identification standard operating procedure (SOP) across all patients attending imaging from the Emergency Department and inpatients.

4. Delay in more detailed investigation

We acknowledge that there was some delay in further investigations being carried out into the circumstances of the radiological error and this meant valuable witness evidence was not included. At the time of Mrs Honeybone's death the Trust was in the early stages of implementing the Patient Safety Incident Response Framework (PSIRF). This framework is now embedded and if a similar incident occurred it would be likely that a hot debrief or after-

action review would take place in a timelier manner, to include all relevant staff in discussions about the incident.

We hope that this information provides you with assurance that the Trust has learned from this incident and refined our processes as a result. This will continue to be monitored carefully through our governance and assurance structures.

Yours sincerely

[redacted]
Interim Chief Executive