Our Ref: 267/2022

JULY 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Re: Your request made under the Freedom of Information Act 2000

Please can I request (under the FOIA 2000):

With reference to the following reporting guidelines set out by NHS Improvement (see page 15, prescribed information 27.1 to 27.5, link here: https://www.england.nhs.uk/wp-content/uploads/2020/08/Detailed_requirements_for_quality_report_-update.pdf)

DC – access denied to the above link.

1) Please tell me in the reporting period 2021/22 the number of deaths that occurred at your Trust for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

DC, unable to say how many deaths occurred at the Trust where a case review or investigation have been carried out. What constitutes a case review? Are cases that have been through SI panel classed as a case review /investigation, does this include cases investigated for the purpose of an Inquest & discussed at SI panel?

I am not aware of which deaths are subject to a SJR, nor the scoring outcomes. The SJR is not part of the SI process of investigation so cannot apply this 'More likely than not ' methodology.

Can you clarify what you are classing as a case review? Is it Serious Incident's (SI) or Inquests?

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NOTE: By 'more likely than not' caused by care, I mean given a score of 3 (probably avoidable), 2 (strong evidence of avoidability) or 1 (definitely avoidable) on the inpatient structured judgement reviews (SJR), as assessed using the Royal College of Physicians avoidability of death criteria. If you do not use this system, please ignore this note.

2) Please provide me with a brief overview of the FIRST FIVE incidents in 2021/22 identified in question 3 (i.e. cases of deaths that were more likely than not caused by problems in care), withholding any identifying information that would run into a Section 40 exemption.

There isn't a question 3 above – presuming this means question 2?

From a data search on reported to STEIS date 2021/22 period, there were 38 SI's reported 3 of which with a 'Harm grading of death'. 2 of those were Inquests firsts which on investigation for the inquest were then reported as SI's.

The 3rd case was escalated to the PST following the ME scrutiny, & family complaint.
Case identified by Medical Examiner (ME) due to the AV fistula procedure leading to ischemic left hand. Family raised concerns with ME as to why this was not picked up when he was admitted on the 28/2/21 when he presented with an infected finger.
Family have submitted a formal complaint to PALS about this and the clinical decision for the AV fistula and its ongoing management.
Post mortem completed: 1a Upper Limb Steal Syndrome (AV Fistula) 1b) End Stage Renal Failure 1c) Diabetic nephropathy II) Generalised Atherosclerosis with Myocardial fibrosis.
73 year old man with multi comorbidities had an AV fistula (left arm) procedure on the24/2/20 in preparation for dialysis. However, dialysis was subsequently not commenced and the AV fistula remained unused.
He then came into A&E on 28/2/21 with infected left index finger which was treated as a fungal infection. He was discharged on the 3/3/21. He was further admitted on the 12/4/21 with cholecystitis and prescribed antibiotics. During this admission he complained of worsening pain in his Left index finger.
Vascular review has found ischemic left hand and diagnosed with AV steal syndrome. He was considered too unfit for theatre and it was deemed a terminal event due to the worsening ischemia. He was placed on the EOL care plan after discussion with the family.
The patient died on 25/04/2021 his death was referred to the Coroner who has confirmed the case is not for Inquest.

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A 4th case which was reported as an SI based on the appropriateness of an earlier discharge from ED – following investigation this was found to be appropriate & the SI delogged. However following that discharge the patient had a fall at home resulting in admission & a requirement to have surgery for fracture femur bone – during the operation as cement was introduced as per procedure the patient collapsed, deteriorated & died. This aspect of the patients death was subject to Inquest and investigated accordingly.

On examination of the data held on Datix risk management – by searching for incident date within the criteria of 21/22 & Harm grading death & removing all those that were reported in relation to HA Covid infection. There are 12 records graded as Death Some of these were reported as SI's after March 2022 so are currently under investigation.

By searching criteria of Date reported within 21/22 (01/04/21-31/03/22) there are 157 records showing Harm death' removing all Hospital Acquired Covid deaths this leaves - See spreadsheet 2

To identify what return is given for this, we need to determine what criteria we are going to use – Date reported on Datix, Date of Incident or if just SI's date reported on STEIS. All will give different date outputs.
The answer for this question will differ when using the different searches as listed above

3) Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

Do we need Conclusion from SI reports ? What about deaths that were not SI's JUST SI'S
What for those linked to /just Inquests is learning identified? NO

Actions – is this entire action plans? YES