Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202223/141
From: Private Individual

Date: 18 July 2022

Subject: Number of investigations into deaths for 2020/21

With reference to the following reporting guidelines set out by NHS Improvement (see page 15, prescribed information 27.1 to 27.5, link here)

Q1 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.

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.

A1 There have been 10 deaths in the financial year 2021/2022 where the structured judgement reviewer felt that there was one of the three degrees of avoidability as per the Royal College's avoidability criteria.

The structured judgement review (SJR) is carried out by a senior clinician with expertise in the specialty in which the death arose. This SJR is then circulated to the members of the Mortality Review Committee. This committee not only has specialists in the same specialty, but all the specialties covered by this Trust. The review is then scrutinised by this panel and the decision on avoidability finalised.

In the vast majority of cases this remains at the same level of avoidability as designated by the reviewer. Any death that falls into any of these three categories then goes on to have a full root cause analysis (RCA). Both the review and the RCA are then discussed at the divisional Mortality and Morbidity meetings so learning can be disseminated. They are also discussed in the divisional governance meetings.

Q2 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.

A2
a. Patient presented with an acute coronary syndrome in heart failure with a low cardiac function and mitral regurgitation. The patient had extensive comorbidities. The patient underwent Mitral and coronary surgery. Postoperatively they were transferred to the ward following a stay in critical care. Patient became oliguric and confused. Patient sustained a fall and was found to be hypoglycaemic. Not long after this the patient had a cardiac arrest and resuscitation was unsuccessful

b. Patient underwent Coronary Artery Bypass Graft (CABG). Past medical history included Diabetes, morbid obesity, deep vein thrombosis. In the post operative period the patient had left sided pneumothoraces. An anterior drain was inserted for this on the last occasion, this drain damaged the heart and the patient did not survive this event

c. Patient underwent CABG. At surgery the left anterior descending coronary artery was opened and required an endarterectomy. This failed on table and was done again with the assistance of a second consultant surgeon. After the surgery the patient passed away with an extensive anterior infarct

d. Patient transferred as an acute coronary syndrome and underwent Percutaneous Coronary Intervention (PCI). At the PCI there was vascular rupture of the coronary which was treated with a covered stent but the patient developed tamponade. A drain was placed but this damaged a chest wall artery. Although this was dealt with percutaneously the patient continued to deteriorate and died.

e. Patient underwent Aortic Valve Replacement & root replacement having previously had a CABG more than 20yrs previously and a kidney transplant 4 years previously. At the end of the procedure when the pleural spaces were being cleared of any collected blood a lung laceration ensued. Despite senior thoracic consultant assistance with lung resection the patient continued to deteriorate and died.

Q3 Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

A3

a. Learning points: More specific instructions could have been handed over to the ward team regarding increasing fluid balance and hyponatraemia or delay discharge from critical care until a negative fluid balance trend is being observed. Lack of formal cognitive assessment despite concerns from family and physiotherapy. Failure to perform a sepsis screen despite a trigger of MEWS of 5 following the initial deterioration / fall. Timing of the fall occurring just prior to hand over time between day and night team might have caused a delay in early escalation of treatment. Severe hypoglycaeamia should be an automatic trigger for an urgent senior medical review

   Presented at the Surgery & Anaesthesia Mortality and Morbidity meeting with RCA. Lessons learnt disseminated via Divisional governance meeting

b. Main issue was around the choice to insert an anterior drain in post CABG patient who had loss of volume of the L hemi-thorax. The chest drain policy has been re-written. All surgical trainees now mandated to attend a drain insertion course at the Trust. Also needs to be discussion as to what equipment should be available on the chest opening/arrest trolley.

   Presented at the Surgery & Anaesthesia Mortality and Morbidity meeting with RCA. Lessons learnt disseminated via Divisional governance meeting
   Individual involved subject to a maintaining high professional standards investigation

c. Learning points: Poor quality angiogram from referring Trust. Either referring clinician or accepting clinician should have discussed this patient at Multi-Disciplinary Team to discuss benefit of surgery. Endarterectomy once chosen led to the demise of the patient – Perhaps didn't need doing as good Diagonal graft already placed. Poor documentation with multiple edits to pre-op and operative documentation carried out after patient's demise.

   Individual feedback and learning via Mortality Review Group chair and Clinical lead.

   Presented at the Surgery & Anaesthesia Mortality and Morbidity meeting with RCA. Lessons learnt disseminated via Divisional governance meeting

d. The following issues were identified and discussed at the Cardiology Mortality and Morbidity meeting together with the RCA findings.

   i. Time available for, and the approach to, the receipt and assessment of day case Acute Coronary Syndrome transfers.
   ii. Delegation of consent.
   iii. The management of complex decisions regarding treatment options with the patient 'on the table'.
   iv. The conduct of the balloon post dilatation, creating coronary perforation. The conduct of the pericardial drainage procedure(s) - the resulting trauma and the failure to insert a drain.
   v. The potential complication in femoral venous sheath placement.
   vi. What is the best and correct response to multiple bleeding sources.
   vii. Gaining access to the optimum access to tests for coagulopathy.

   Lessons learnt disseminated via the Medical Divisional governance meeting

e. Learning Points: Findings of RCA and SJR that Yankauer sucker can get damaged by fantail saw on redo sternotomy. Damaged Yankauer sucker used to suck out lungs, lungs left inflated – both of these can injure the lungs – New Standard Operating Procedure that Yankauer sucker changed after opening with fantail saw, lungs deflated during this procedure.

   Presented at the Surgery & Anaesthesia Mortality and Morbidity meeting with RCA. Lessons learnt disseminated via Divisional governance meeting