Mersey and West Lancashire Teaching Hospitals NHS Trust

Ref. No:	1056
Date:	04/07/24
Subject:	Care provided to the patient.

REQUEST

1) Please tell me separately for 2022/23 and 2023/24 the number of deaths for which a case record review or investigation has been carried out leading to the conclusion that they were more likely than not to have been due to problems in the care provided to the patient.

NOTE: I understand that one widely used method for determining this is the Royal College of Physicians' Structured Judgement Reviews (SJR) 1-6 system. If this system was used, by "*more likely than not*" I'm referring to cases with scores of 3 (probably avoidable), 2 (strong evidence of avoidability) and 1 (definitely avoidable).

2) Please provide me with a brief overview of the FIRST FIVE incidents (in 2023/24 preferably or from 2022/23 if the former is not yet available) identified in question 1 (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.

3) Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of these five cases highlighted in question 2?

RESPONSE

Mersey and West Lancashire Teaching Hospitals NHS Trust response

1 2022/2023 – deaths due to problems in care = 0

2023/2024 - deaths due to problems in care = 2 (Nb: not all SJRs complete for this year yet)

2 Case 1

Summary - Cause of death, cardiac arrest

Case 2 – Cause of death, respiratory failure

3, Lessons learnt and actions

Case 1
Lessons learned

- Vital sign observations not completed as required.
- Delayed action into agitation with involuntary movements.

Action taken

- Circulation of clinical guidance to relevant clinical staff
- Communication regarding observation policy sent to staff

Case 2
Lessons learned

- Delay/failure to identify Type 2 respiratory failure.

Action taken

- Noninvasive ventilation was added to the electronic prescribing system.