Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Information Governance Department
Suite 9
Buckingham Row
Brick Kiln Lane
Wigan
WN1 1XX

Email: foi@wwl.nhs.uk
Web: www.wwl.nhs.uk

Ref: FOI/2024/9975

Date Received: 3rd July 2024

Response Due: 31st July 2024

Date: 29th July 2024

Dear Sir/Madam

With reference to your request for information received on 3rd July 2024, I can confirm in accordance with Section 1 (1) of the Freedom of Information Act 2000 that we do hold the information you have requested. A response to each part of your request is provided below.

In your request you asked:

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).

   2022/23 = 6
   2023/24 = 11

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.**

   2023/24
   - Failure to detect deterioration.
   - Diabetic delays.
   - Potential anaphylactic reaction.
   - Failure to transfer.
   - Anaesthesia issues.

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?

There has been an improvement in staffing and monitoring particularly of patients in corridors and waiting areas to help with detection of deteriorating patient sooner. We have developed a Diabetic MDT (Multi-Disciplinary Team) to plan care for patients in a more timely way. However, some areas are less amenable to change due to the Trust not being in control of waits for transfers. Individual human error has happened with the anaphylaxis, and we are reinforcing good practice and providing warnings about risks.

If you are not entirely satisfied with this response, please do not hesitate to contact the Information Governance Department via the email address provided. If we do not hear from you within 40 days, we will assume that we have been able to accommodate your request under the Freedom of Information Act 2000.

Yours sincerely,

Sanjay Arya
Medical Director

PLEASE NOTE:

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to: Information Governance Department, Wrightington, Wigan and Leigh NHS Foundation Trust, Suite 9, Buckingham Row, Brick Kiln Lane, Wigan, WN1 1XX.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision at:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire, SK9 5AF

Helpline number: 0303 123 111