Ref: Reg28/CW/Jun18

The Dudley Group
NHS Foundation Trust

Russells Hall Hospital
DUDLEY
West Midlands
DY1 2HQ

22 June 2018

Private and Confidential

Mr Zafar Siddique,
Senior Coroner
Black Country Coroner's Court
Jack Judge House
Halesowen Street
Oldbury
West Midlands
B69 2AJ

Dear Mr Siddique,

Re: **Response to Regulation 28 Report to Prevent Future Deaths – The late Mrs Christine Withers**

I am in receipt of your Regulation 28 Report to Prevent Future Deaths following the inquest, and your ruling on 23 April 2018 in respect of the late Christine Withers. I should extend again the condolences of the Trust to Mrs Withers' family.

The **MATTERS OF CONCERN** are as follows:

1. Evidence emerged during the inquest that no repeat blood tests were performed to measure the potassium levels despite this being recommended by the Consultant at the ward round in the morning.

2. There was inadequate communication by nursing staff with the family who expressed concerns about the decline in Mrs Withers.

The important issues you raise have been taken very seriously and following the inquest into the sad death of Mrs Withers, the Chief of Medicine and Integrated Care has reviewed the guidelines relating to the management of hypokalaemia in adults. **Appendix 1** details the revised document which has been approved by the Chair of the Clinical guidelines group. This revised guideline has considered the most recent medical evidence and provides clinical staff with a consistent tool to treat and advise patients on the clinical management of low potassium levels.
This guideline will be publicised on the Trusts intranet site and has been circulated to all medics in the Trust. A further presentation of these guidelines is scheduled in July at the Medicine Audit / Governance Meeting.

On review of the patient's medical and nursing notes it was clearly documented that a number of conversations were had with the family regarding treatments and the medical plan in place for Mrs Withers. Staff, at the time, did feel that they had communicated effectively and that they were acting on the clinical assessments and needs of the patient. However, staff had documented that the family at times, appeared unhappy with the answers given.

Upon reflection, staff have revisited this episode of care and have concluded that they had not focused sufficiently on the family's emotional wellbeing and the stress that they were under at this very difficult time and agree, that they should have offered more support to the family.

As this was a large family, it may have been more beneficial to have appointed a lead person within the family to cascade information to the rest of the relatives, or arrange a meeting to discuss the best way of communicating in the future.

In response to this sad event all the staff within Ward C4 are working with our palliative care champion to complete the in-house palliative care competencies which comprehensively covers communication with patients, families and carers.

I trust the information provides assurances to you that The Dudley Group NHS Foundation Trust has taken appropriate action to address the matters of concern raised.

Yours faithfully,

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Diane Wake
Chief Executive

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