NHS
East Suffolk and North Essex
NHS Foundation Trust

Trust Headquarters
Colchester Hospital
Turner Road
Mile End
Colchester
Essex
CO4 5JL

Mr Lincoln Brookes
Coroner for Essex
A Block
Chelmsford County Hall
Victoria Rd S
Chelmsford
CM1 1QH

Date: 23 November 2020

Dear Mr Brookes,

Re: June Patricia Margaret Parlour (Deceased)

I am writing in response to the Regulation 28 Report to prevent future deaths issued following the inquest of June Patricia Margaret Parlour.

ESNEFT is committed to learning lessons and taking action to ensure the future safety of patients in our care. We have taken following actions in response to the following concerns detailed within your report:

1. ***During the course of the hearing it became apparent that staff on the ward (whether doctor or nurse) were not familiar with either the national morphine guidelines (BNF) or indeed those of the hospital. The Court is concerned that such lack of awareness may not be limited to that ward or that hospital.***

   We have reviewed and updated the ESNEFT Morphine Administration Guideline and the Naloxone Administration Guideline in line with those set out in the British National Formulary (BNF). Both guidelines have been communicated to staff through the Chief Medical Officers 'Doctors Round' and the Chief Nurse Brief. Further to this, the guidelines are published on the Trust intranet and on the medications specific application 'Medusa' where they are easily accessible by staff in all areas within the Trust.

   To capture Doctors in training, the Medical Directors of Education have engaged and communicated the guidelines, and updated the junior doctor induction programme to ensure this is embedded in practice moving forward.

   The use of Morphine and Naloxone are monitored through the Controlled Drugs Steering Group through review of all incidents reported. There is a current programme of Opioid auditing which takes place across the Trust.

2. ***It was concerning that even the hospital's own Serious Incident report had incorrectly quoted the hospital's guidelines as to the safe dose of IV morphine and that neither the investigatory team or any of the clinical staff who subsequently read that report had picked up on this.***

   We are disappointed that this was not picked up within our serious incident approval process and will ensure closer attention in the future.

The Trust has been selected as one of the early adopters for the new NHS Patient Safety Incident Response Framework, which commenced on the 2 November 2020. In establishing the new framework ESNEFT has put in place a number of highly trained investigating officers to lead the patient safety incident investigations, utilising relevant clinical experts within the process. Through a team approach to investigations, greater scrutiny of the information and evidence provided will be undertaken and will support a timely response to incidents and the identification of improvements required. The framework aims to ensure investigations are undertaken in a timely manner and with a greater involvement of patients, families and carers.

3. ***I am concerned as to the adequacy of education re safe morphine doses that newly qualified doctors and locum doctors receive, and how this is audited.***

   As mentioned above we have updated the junior doctor induction programme, incorporating an additional module specific to prescribing high risk medications (such as Morphine) and introduced additional training for our higher grade doctors in training.

   We have updated our locum and agency staff induction, with includes signposting to the relevant documents on the intranet and on the Medusa system. All locum and agency staff, in conjunction with the local ward team complete an induction form which is subsequently sent to the Education Team who monitor adherence with the induction process.

4. ***I am concerned that the hospital's own guidelines regarding morphine administration for acute pain management have not been revised since 2013 and are at odds with the current BNF guidelines (in terms of appropriate doses and patient vulnerability).***

   We have reviewed and updated the ESNEFT Morphine Administration Guideline and the Naloxone Administration Guideline in line with those set out in the British National Formulary (BNF).

   We have also updated the ESNEFT Acute Pain Guideline, which is scheduled for approval by the Medications Governance Group at its meeting on 03rd December 2020. This guideline will be subject to audit by the Acute Pain Team. This meeting is held bi-weekly in response to the pandemic.

   Further to this, all opioid related medication guidelines are within their review dates.

5. ***I was concerned that this incident arose as a result of a doctor and a nurse failing to understanding each other, and the nurse subsequently feeling that she had no choice but to administer an IV dose that she believed to be dangerous, and in particular that:***

   a) The drug charts design did not facilitate clear instructions for titration for one-off doses of IV morphine.

   Through a QI process we have developed and approved a new Morphine Prescription sticker for use on prescription charts across all inpatient areas. These are currently out to printers, with a planned roll out programme to take place in December 2020. To close the loop on the QI process this will be subject to audit by the Acute Pain Team.

   Further to this we have updated the Morphine Administration Competency Framework for inpatient staff who administer and monitor morphine administration.

b) The nurse did not feel confident enough to challenge the prescription (as she perceived it) effectively or escalate / refer to another doctor.

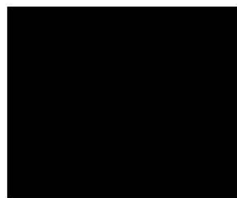
We anticipate that the introduction of the Morphine Prescription sticker will provide clarity of prescription and support raising a concern when required.

ESNEFT encourages all staff to speak up and has a positive reporting culture with regards to patient safety. Work is on-going in accordance with the 'Just Culture Guide', through the Patient Safety Incident Response Framework and through the NHS Programme of Patient Safety Specialists across the NHS.

All nursing staff have been reminded that there is a Duty Matron available 24/7 and consultants on-call, to whom all staff can escalate any concerns or ask questions, in addition to the Consultants on-call

Again I offer my assurance that ESNEFT is committed to learning lessons and taking action to ensure the future safety of patients in our care.

Yours sincerely



Chief Executive