Your ref: [redacted]
Our ref: [redacted]
Date: 13 January 2021

[redacted]
Medical Director
Trust Headquarters and Medical Education Centre
Aberford Road
Wakefield
WF1 4DG

PA: [redacted]

Mr K McLoughlin
Senior Coroner
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

Dear Mr McLoughlin

Re: Inquest touching the death of Leslie Clewarth (deceased)

I am responding on behalf of the Trust to the Regulation 28 Report to Prevent Future Deaths issued by yourself to The Mid Yorkshire Hospitals NHS Trust on 10th November 2020.

The Matters of Concern raised in your report were: -

1) *Without adequate records showing the care provided or dosage administered, it was not possible to corroborate the testimony of nurses who had attended to Mr C on the afternoon he died. This fuelled the suspicions raised by his daughter and her husband.*
2) *Drugs which were left unused after Mr C's death were not accounted for*

Without proper records there is a risk that essential care may not be provided or is erroneously duplicated, thus potentially putting a patient's safety of health at risk.

I would like to thank you for bringing these matters to our attention. I absolutely agree that clear documentation is key to ensuring patient safety.

In order to respond to this Regulation 28 notice we have taken the opportunity to review our Trust Syringe Pump Policy, the Trust Syringe Pump combined prescription and administration chart and the relevant sections of our Trust Medicines Management Policy. In addition we have audited 10 cases from gate 34 where patients were having medication administered via a syringe pump that was subsequently discontinued at the end of their life against the syringe pump policy.

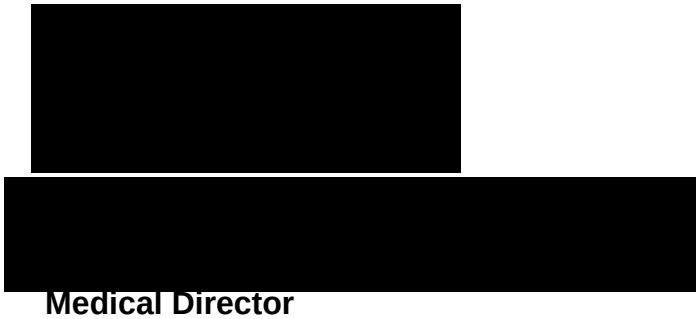
Chairman – [redacted]

Chief Executive – [redacted]

In light of the above reviews we have determined that the syringe pump policy and the prescription / administration chart should be revised to provide clearer guidance and support better adherence to the policy. In particular this relates to the recording of any medication remaining in the syringe at each check and the amount discarded at the change or end of the use of the syringe driver and a prompt to support staff in recognising when the next syringe change will be required. Once the revised policies have gone through the appropriate governance routes in the Trust there will be further training delivered to support their use.

Once again thank you for bringing these matters to our attention.

Yours sincerely



Medical Director