OFFICE OF THE CHIEF MEDICAL OFFICER

NHS
Medway
NHS Foundation Trust

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY
[redacted]

10th January 2023

Ms Catherine Wood
Assistant Coroner
Mid Kent and Medway Coroners
Cantium House
County Hall
Sandling Road
Maidstone
Kent
ME14 1XD

Dear Ms Wood,

Prevention of Future Deaths Regulation 28 Report
Sally-Ann Few (Sally-Ann Bester)

We refer to your report issued following the inquest touching upon the death of Sally Ann Few dated 15th November 2022 pursuant to Regulation 28 of the Coroner's (Investigations) Regulations 2013.

Background:
Sally-Ann Few had a past medical history of chronic obstructive pulmonary disease, entrocutaneous fistula, chronic gastric ulcer, pulmonary embolism, depression with a previous paracetamol overdose in 2020 and alcohol dependence. She had a prolonged hospital admission from July 2021 following a perforation of her gastric ulcer leading to months in hospital and necessitating intubation and a tracheostomy. She was discharged home and a medication review conducted by a community pharmacist on 15th December 2021 led to a decision to change her Oromorph to slow-release Zoromorph. A review by the same pharmacist led to discontinuation of the Oromorph and she was maintained on the slow-release prescription alone as her pain was under control.

Sally-Ann was readmitted to hospital on 1st March 2022 with a deterioration in her breathing, shortness of breath and biphasic stridor which led to a diagnosis of cricoarythenoid fixation due to her period of prolonged intubation

Pharmacy reviewed and completed a drug history of the patient's medication on Thursday 3rd March. This drug history was completed using sources of the patient, patient's medication, and the Kent Summary of Care record (this is in accordance with the current Trust Medicines Reconciliation Policy). This established that the patient was prescribed and had been taking Morphine preparations prior to hospital admission as well as a number of other medications including citalopram.

There was one issue identified during the drug history, Oramorph (short-acting morphine sulphate [redacted] liquid preparation) had been prescribed on the drug chart at a dose of [redacted] twice a day. The patient was normally prescribed Zomorph

(long-acting morphine sulphate capsule preparation) [redacted] twice a day. The pharmacist addressed this issue on Tuesday 8th March, documenting in the notes that the prescribers needed to review the switch. However Sally-Ann continued to receive Oramorph until discharge. Her final dose of Oramorph [redacted] was 8:00am on Friday 11th March. The discharge letter shows that on discharge Oramorph [redacted] twice a day was ceased and changed to [redacted] every four to six hours when required. Zomorph was restarted at a dose of [redacted] twice a day. These dosages are the same dosages Sally-Ann was prescribed on admission according to the documented drug history.

She was provided with [redacted] of Oramorph and 2 weeks supply of Zomorph. She was found dead at home on the morning of the 12th March 2022 and the bottle of morphine she had been discharged with was nearly empty

The following is our response in relation to the matters of concerns raised:

1. **Evidence given at the inquest revealed that the system at the GP practice when examined by the pharmacist at the hospital did not show that the Oromorph prescription had been stopped.**

   This observation relates to a potential discrepancy between the information held on the GP record which feeds information into the Kent Summary of Care Record (used as a data source for medicines reconciliation on admission) and the adjustments to morphine regime subsequently undertaken by the primary care pharmacist.

   The Trust Pharmacy team has contacted representatives of the Kent & Medway ICB Medicines Optimisation team that cover Medway & Swale. They are currently investigating the review process by the pharmacist to understand how the dose and product changes made were recorded and communicated to the GP practice. They are also investigating why these changes did not appear in the Kent Summary of Care Record.

2. **Evidence was heard that Mrs. Few whilst an in patient was prescribed Oromorph and not Zoromorph the drug she had been using at [redacted] twice a day. The effect of which may have impacted upon her pain control but the evidence did not show she had high pain scores. A pharmacist recognised this discrepancy on 8th March and asked for this to be reviewed. No such review took place and it was difficult to see on the electronic records system that such a review needed to take place as apparently there were no highlights or flags to alert the doctors that such a review needed to take place.**

   The Trust implemented an Electronic Patient Record (EPR) system in November 2021 and an Electronic Prescribing & Medicines Administration (EPMA) system in September 2022.

   The EPMA system is being continuously developed and enhanced to improve patient safety, and whilst there is a section now included for Pharmacists to add notes to electronic prescriptions, the Trust is seeking to develop

functionality that would create a warning alert that would trigger a review by a doctor. The system is fully auditable and will identify who triggered the action, when it was viewed and what response is made. A feasibility meeting is being booked for key stakeholders at the beginning of January 2023.

In the interim, Pharmacy staff have been reminded that their professional responsibility does not end with a note flagging a potential medicines issue, but there is an expectation that recommendations should be followed through to a conscious decision to either endorse or reject a recommendation.

As a collaborative approach, the Trust Pharmacy team and ICB Medicines Optimisation teams have agreed to present the information in the form of a case study to Pharmacy colleagues at a future meeting of the Controlled Drug Local Intelligence Network (CDLIN) to share learning

3. **At the inquest it was clear that the standard of record keeping by the medical staff was poor and it was only by hearing from witnesses via statements and orally, including from her family, that the decision making around her care and plans for her management became clear, as there was very little written in the notes. In particular there was no evidence of why decisions were made, what discussions were held and what advice was given.**

   Sally-Ann Few (Sally-Ann Bester) was seen by either a consultant or another senior ENT doctor on a daily basis during her inpatient stay as part of the daily ward rounds. The daily decisions taken regarding treatment of her airway condition were documented. The reasons for the decisions were clear to the treating team, but may be less clear to clinicians and others who were not team members and the ENT clinicians have been reminded of the need to both continue to document decisions on the daily ward round *and* additionally document the reasons why the decisions were made. The electronic discharge summary completed on 11th March 2022 did explain the decision making process and the options that had been discussed. It is acknowledged that the medical notes did not include any discussion regarding opiates as the ENT medical team's understanding throughout the admission was that the prescribed opiates were those which were being taken on admission.

   We thank the Assistant Coroner for raising this with us and highlighting the opportunity for an improvement in our process.

Yours sincerely,

[redacted]

[redacted]

Chief Medical Office