East Suffolk and
North Essex
NHS Foundation Trust

Ms Sonia Hayes
Area Coroner for Essex
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Colchester General Hospital
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12 August 2024

Our Reference: [redacted]

Dear Ms Hayes

REGULATION 28 REPORT TO PREVENT DEATHS – INQUEST TOUCHING UPON THE DEATH OF CHLOE HUNT WHICH CONLUDED ON 19 JUNE 2024

I write in connection with the above mentioned Inquest and the Regulation 28 Report to Prevent Deaths issued by yourself on 19 June 2024.

I would like to take this opportunity to extend my condolences to Chloe's family for their loss.

The Regulation 28 Report to Prevent Deaths issued by yourself on 19 June 2024 highlighted concerns relating to Colchester Hospital, those concerns were expressed as follows:

a. Chloe explained on 11 March 2022 in Accident & Emergency to the doctor her background of complex trauma and how difficult she found it to be in hospital. This was not factored into a plan for treatment.

b. Imaging established Chloe had swallowed 3 full-sized pens, 2 free in her stomach and 1 was impacted in her duodenum. There was a lack of consideration of the complexities of removal to guide whether the removal should be endoscopic or surgical. Endoscopy could not be converted into a procedure under anaesthetic in the interventional radiology suite.

c. The requirement for reintubation after each pen removal and the difficulty for a patient to tolerate multiple procedures without anaesthetic was not considered for Chloe on referral for removal, or whether this might need to be converted to a procedure under anaesthetic.

d. There was a lack of urgency in treating Chloe and lack of recognition of her deteriorating clinical condition.

e. Chloe was tachycardic throughout her admission with low blood pressure and there was no investigation of the underlying cause in a young otherwise physically healthy woman. NEWS Scores should not replace consideration of the whole clinical picture for a patient.

f. In the hours before Chloe's death, she required oxygen for the first-time that was administered for approximately 75 minutes and Chloe's heart rate reduced to normal for

several hours for the first time in her admission. This reduction was not sustained, and her heart rated elevated later. These changes were not recognised as signs Chloe was a deteriorating patient.

g. Chloe's low oxygen saturation level and the prescription of Oxygen was not documented on 14 March.

h. From the timing of the recognition of Chloe's in-hospital cardiac arrest there was approximately 10 minutes before the first heart rhythm was recorded during the resuscitation.

The information presented below is intended to describe the actions which have been taken/are being taken East Suffolk and North Essex NHS Foundation Trust to mitigate the risk of future deaths and address the concerns you have raised.

Chloe's presentation and treatment plan for the removal of foreign objections – points a) – c) raised above.

Chloe presented to the Emergency Department on Friday afternoon 11 March 2022 and was admitted to hospital. Upon assessment on 12 March 2022 it was deemed that a conservative management plan should be taken. Having reflected on this decision making it is accepted that there was no benefit to this management plan and a different course of action could have been considered over the weekend.

Having reviewed the decision process taken on Monday 14 March 2022, it is noted that the available imaging did not confirm that a pen was impacted, and the clinicians caring for Chloe could only establish that the pen was impacted by undertaking an endoscopy. Up to this point, it was the working diagnosis that the pens could all be removed safely under endoscopy.

When considering how best to proceed in Chloe's case, a number of factors were taken into account including reviewing the records of previous endoscopies, the ability to tolerate those procedures, Chloe's risk profile and the risks of surgery, the clinical information available at the time and the informed consent provided by Chloe at the time to proceed to endoscopy.

It is the Trust's view that having assessed all the above factors, it was clinically indicated to proceed to endoscopy and it was reasonable to do so. However, having established at endoscopy that a pen was impacted and required surgical removal, it is recognised that communication between the clinical teams should have taken place to decide next steps. This would probably have been to end the endoscopy procedure and re-list Chloe on the emergency operating list for a procedure (either further endoscopy or an operation) under general anaesthetic on 14 March 2023, rather than waiting for a place on the emergency list the next day. This however would have also required a priority assessment against the cases already in the list.

Every day the Trust has an emergency theatre list for procedures usually carried out under general anaesthetic, which is used by all specialities within the Trust. This list runs 24 hours a day if required. All emergency operations are placed on the list and the clinicians responsible for conducting the emergency theatre list (surgeons and anaesthetists) meet daily to prioritise the patients on the list and then carry out the procedures in order of priority. Although not a daily occurrence, emergency procedures might also include endoscopy under general anaesthetic from time to time.

Chloe's case has been presented at the governance meeting and morbidity and mortality review to take the learning out of Chloe's case and circulate the areas in which decision making can be improved.

Recognition of Chloe as a deteriorating patient – points d) & f) raised above

Chloe's admission has been reviewed for signs of deterioration.

It is noted that on the evening prior to her cardiac arrest, Chloe was still taking her tablets herself with sips of water. Chloe got up to go to the toilet at 3:45am and interacted with the nurses about her cannula/drip stand. While Chloe was asking for pain relief, there is no clear evidence that Chloe had suffered a perforation, nor was the description of Chloe's presentation and interactions on the evening a sign of a patient who was about to have an event relating to an upper gastrointestinal obstruction and grossly abnormal electrolytes.

The only abnormality detected in the admission was Chloe's mild tachycardia. This point is addressed below.

Having reviewed Chloe's case it appears as there was no clear indication that Chloe was about to suffer a sudden acute event relating to an upper gastrointestinal obstruction and grossly abnormal electrolytes.

However, it is noted that there may have been an opportunity to explore clinical reasons for the requirement of pain relief, including conduct a further set of observations at that point and exploring reasons for persistent tachycardia (detailed below).

Chloe's case has been discussed with staff members, through the daily ward huddle and the Two at the Top meeting (outlined below) as well as at the joint governance meeting to promote learning from Chloe's case and highlight additional actions that can be taken to help establish potential underlying causes for abnormalities in an otherwise seemingly stable patient.

Investigation of tachycardia – point e) raised above

Chloe's notes have been reviewed and it is noted that almost all of Chloe's electrocardiograms undertaken since 2020 show a sinus tachycardia and this is replicated throughout most of Chloe's admissions, where her observations show a sinus tachycardia.

The cause of persistent tachycardia can be difficult to determine in patients who are receiving medications which in themselves, can be the cause of tachycardia.

The Trust has however reviewed the case and acknowledge that a further electrocardiogram could have been undertaken during the admission to provide further clinical insight into Chloe's condition.

This learning point has been circulated to staff members, through the daily ward huddle, reiterating the need to consider persistent tachycardia signs and to undertake further investigations to establish the underlying cause.

Oxygen prescription – point g) raised above

The Trust would like to take this opportunity to provide assurance that whilst the saturation level and oxygen administered on 14 March 2023 were not recorded in the notes, the low saturation level was clinically recognised and appropriate steps were taken to address this, by administering oxygen.

The Trust has however acknowledged that the low saturations were not recorded in the notes. This learning point has been circulated to staff members, through the daily ward huddle, reiterating the need for oxygen saturations to be recorded prior to the administration of oxygen.

The Trust has also circulated a further copy of the Emergency Oxygen Use in Adult Patients policy which gives staff clear guidance on prescribing, administering and monitoring oxygen.

To ensure patient's notes are being completed in the correct manner, the Matron for the ward conducts a spot check on drugs charts once a week to make sure the drugs charts on the ward are being completed correctly. Where a dose is omitted, an electronic incident report is raised and then reviewed for the Two at the Top meeting. This is highlighted to the staff though the weekly review of the drugs charts.

The Two at the Top meeting is a monthly governance meeting which takes place to review various areas of patient care and safety at a senior clinician level. It covers areas such as patient management, NEWS & sepsis, medicines management, incident and complaint themes and clinical audits. Any issues with omitted doses are addressed through the governance process from service meeting to divisional board, as well as at ward level, to enable further Trust learning to be implemented in areas of need.

In addition to the steps above, the ward notes are subject to a clinical audit, which are peer reviewed (excluding Acute Kidney Injury and Sepsis which are done at ward level) from an external team, who visit the ward monthly and carry out a review of a randomly selected 10 patient notes, reviewing these against the quality standards. This enables the ward to obtain an external view on note keeping and promote learning established from outside the ward.

The Trust has recently signed a contract with EPIC to transition its patient records system to an electronic system, meaning that by 2025, all ESNEFT patient record keeping will be done electronically.

This will have the benefit of being more user friendly and provide greater compliance with completing documents, as the system is able to be programmed to ensure areas of information are documented before being able to proceed through the system. It is also possible to set alerts that are triggered by timeframes to ensure staff are notified of any immediate actions that need to be carried out.

Resuscitation – point h) raised above

The Trust would like to take this opportunity to provide assurance that as soon as Chloe was found to be in cardiac arrest, basic life support was administered immediately, comprising of chest compressions.

On this occasion, whilst chest compressions were being administered to Chloe, the resuscitation trolley on the ward was sourced and attempts were made to connect the defibrillator leads but these attempts were not successful. A further resuscitation trolley was obtained from a nearby ward.

The defibrillator leads were then connected and a rhythm was obtained. It therefore appears the initial unsuccessful monitoring attempts were a result of operator error.

Through the Stanway ward huddle, all band 5/6/7 staff on the ward have been asked to book onto Immediate Life Support training through the Trust's training portal to ensure that there would be a member of staff on each shift that has had the Immediate Life Support training, which includes the use of defibrillators.

Discussions have also been held with the Resuscitation Committee at a recent meeting to make a recommendation that all band 6 & 7 nurses on adult in-patient wards should have Immediate Life Support training as role essential training. Some band 5 nurses in specialist / required areas will also

need to be included. This proposal will be undertaken as part of the Resuscitation Training Needs Analysis that is underway and will need executive approval.

In addition, the Matron carries out a monthly quality audit. This is an online form that is completed by the Matron. The Matron's quality audit includes making sure the resuscitation trolley has been checked daily and fully checked weekly, and signed as being checked. This quality audit will allow the Trust to identify any issues with resuscitation trolleys and address these.

I hope the above information demonstrates the learning and training that has been implemented to cover the concerns of the Coroner.

I once again would like to extend my sincerest condolences to the family of Chloe for their loss.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

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Chief Executive Officer
East Suffolk & North Essex NHS Foundation Trust