NHS
Mid and South Essex
NHS Foundation Trust

H.M Area Coroner
Ms Sonia Hayes
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

Our Ref: [redacted]

[redacted]

10 February 2025

Dear Ms Hayes

Regulation 28 Report to Prevent Future Deaths – Mary Margaret Whitlock

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) dated 17th December 2024, relating to the Inquest touching on the death of Mrs Whitlock.

We have considered your concerns and set out our formal response to each matter using your numbering as follows.

Matters of Concern

1) **Morphine in the form of 5mg Oramorph and then 2.5mg Intravenous morphine was administered for a patient where the medication record noted allergy to Tramadol, Codeine and Buprenorphine. Naloxone was required to reverse the effect. Whilst this did not cause or contribute to this death this matter was not part of the Trust review, and no safeguarding was raised.**

   I am advised by Emergency Department colleagues that a small dose of opiate was given to treat Mrs Whitlock's pain, which was the likely source of her agitation.

   Mrs Whitlock had already received IV paracetamol therefore the options for effective analgesia were unfortunately very limited. The options were liquid ibuprofen, IV Ketorolac (available in theatres only) or Diclofenac. However, these options would have taken time to arrange, administer and take effect in a patient that was agitated, distressed, and not complying with immobilisation therefore increasing the risk of further injury.

Clinical decision making at the time indicated the selection of IV opiate to deliver the faster onset of analgesia and it's sedative properties, to gain rapid control of the situation in a more timely manner. It was a calculated risk and the possible need for naloxone was anticipated, with staff being briefed to watch for hypoventilation and hypoxia. It was apparent that the patient was sensitive to the drugs listed as allergies because they either caused sedation or hallucinations.

In retrospect, the clinicians consider that a smaller dose than 2.5mg, of 1mg increments of opiate would have been more appropriate given her noted allergies. Learning from this case has been shared with Emergency Department colleagues accordingly for future practise.

The choice of analgesia was not included as a term of reference for our review as it was within an acceptable range of clinical decision making, and a safeguarding was not triggered or indicated for this event. The use of opioid analgesia was made on a balance of risk basis and the risks of allergy were carefully managed.

In Mrs Whitlock's case, the correct action was taken as soon as a reaction to the opiate was identified and there was no causative effect for her care.

2) **Evidence of clinical witnesses is that Notley Ward was (at the time of this death) and remains understaffed despite escalation within Trust.**

Our Deputy Director of Nursing for Broomfield Hospital has reviewed the staffing position on Notley Ward and confirmed that we have recruited to all vacant Registered Nurse posts, and the ward is at full establishment with no current nursing vacancies.

To ensure that safe staffing levels are maintained across all wards, we have implemented a daily staffing huddle which takes place at 08:15AM Monday-Friday. The huddle review the staffing position across the site and senior colleagues make immediate redeployment/mitigation plans as required. At the weekend, we have a daily duty Matron on site to complete the same function.

We have a duty Matron on site weekdays until 20:00PM to manage any staffing concerns and we have embedded clear escalation processes to the Director and Deputy Director of Nursing who can approve requests to increase staffing by sourcing bank staff/ agency support.

Funded Staff Rota (FSR) reviews are completed on every inpatient ward and our nursing establishments are altered to meet nursing acuity and safe nurse to patient ratios. The FSR's are signed-off at Director of Nursing level.

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3) **No Discharge Summary or Safety Netting advice was provided by the Trust to the care home for a patient with dementia who was discharged from Accident & Emergency at night where she had undergone investigations for traumatic head injury.**

It is of course a fundamental requirement that discharge summaries are completed for all patients and I am disappointed to note that we did not meet our expected standard on this occasion.

Following Mrs Whitlock's experience, all our Emergency Medicine clinicians have been reminded of the requirement to complete a discharge summary to all patients in every case. We have highlighted the importance of these being available to patients who are not being discharged to their own home.

Nursing colleagues have also been reminded to check that this has been completed prior to the patient leaving the department upon discharge.

We have included the learning from Mrs Whitlock's case within our all-staff patient safety bulletin for January 2025 emphasising the importance of a full and accurate discharge summary being completed at the point of discharge.

We plan to monitor our performance with issuing discharge summaries within our 2025 trust-wide corporate audit programme to assure ourselves with compliance and use the results to take action as appropriate.

If I can assist further with these matters, please do not hesitate to contact me.

Yours sincerely

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Chief Executive
Mid and South Essex NHS Foundation Trust