Bedfordshire Hospitals
NHS Foundation Trust

Luton & Dunstable University Hospital
Lewsey Road
Luton
Bedfordshire
LU4 0DZ

T: 01582 491 166

Direct dial: [redacted]
CEO EA: [redacted]

Our ref: [redacted]

Ms Whitting
His Majesty's Coroner's Office
The Court House
Woburn Street
Ampthill
Bedfordshire
MK45 2HX

Date: 14th May 2025

Dear Ms Whitting

Re: Jacqueline Green – Regulation 28 Report to Prevent Future Deaths

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 4 April 2025 concerning the death of Jacqueline Green on 3 September 2023.

In advance of responding to the specific concerns raised in your Report, I would like to express my sincere condolences to Jacqueline's family and loved ones. The Trust are keen to assure you and the family that your concerns raised through the Report have been listened to and reflected upon.

I provide a summary of the matters of concern raised:

1. **HSSIB report implementation at Bedford site** - Despite the fact that the HSSIB made *Safety Observations* to mitigate the risks of unintentional paracetamol overdose in adult inpatients with low bodyweight none of these had been addressed/adopted at Bedford Hospital by the time of the Deceased's admission on 29 August 2023
2. **Nursing actions related to the event** - unanswered questions and further exploration required from the PSII investigation, in particular, request for rationale on the administration of IV paracetamol via the nursing staff during the event and any additional safety concerns to be addressed as a result of this (for example, did nursing staff feel unable to challenge the prescription directly with the doctors?)
3. **Optimisation of Nerve centre information regarding weight accuracy** - Following Nervecentre implementation at Bedford Hospital staff are still able to enter an estimated weight and there do not appear to be any alerts on this system to advise of the need for weight accuracy in the prescription of oral

paracetamol and consideration of the risk of liver toxicity in those weighing under 50 kg (as advised in Safety Observation 02/2022/151);

4. **Additional actions related to monitoring weight to reduce risk** - Practical steps to achieve the outcome to reduce the risk of unintentional paracetamol overdoses (as advised in Safety Observation 02/2022/151) in addition to PSII report action "Patients should be weighed on admission and the information documented", other than the provision of a 'pat slide'

I have undertaken an investigation to respond to the matters of concern raised and to also identify whether there is any further learning for the Trust.

1. HSSIB report implementation at Bedford site

A large amount of work has been undertaken following the HSSIB report, and as a result of Jaqueline's death, to reduce incidences of paracetamol overdoses in patients with low bodyweight. This is an ongoing project to continue to look at areas where further improvement can be made. I provide a summary of the actions taken to date in response to the HSSIB report:

- A pharmacy led QI project and audit conducted cross site led by the medication safety team and presented at the Medical Safety Committee in March 2025. This involved systemic sampling of 200 patients in order to collect data and the prescribing patterns for IV paracetamol. The audit findings were presented at the cross site ward manager and senior nursing meeting on 21st April 2025 and will be presented to the doctors at Grand Round in June 2025.
- A pharmacy led review of stock allocations and IV paracetamol across both sites and memo produced to support switching to oral to promote prudent use of IV paracetamol
- A soft review of IV paracetamol after 24 hours has been introduced on Nervecentre. This will place a reminder prompt on Nervecentre for clinicians pharmacy and nursing teams to review any paracetamol prescription after 24 hours with the aim to reduce prolonged use of IV paracetamol and as a prompt to step down to oral (reducing patient exposure to risk associated with IV paracetamol).
- HS report included in the Trust Medicines Information and Safety Tips Newsletter in September 2023

2. Nursing actions related to the event

In order to address the question raised with the Report, I obtained a statement from the nurse who weighed Jacqueline and administered the dose of 500mg on 1st September. A further statement was requested from the nurse who withheld the dose on 31st August but as they are not directly employed by the Trust I unfortunately have yet to receive this.

Within the nurse's statement, it helpfully clarifies that it was the medical registrar who, on 31st August, asked the nurse whether Jacqueline had been weighed after the IV prescription of 1g had been made. The same nurse had earlier that day administered the prescribed amount of 1g IV paracetamol. The doctor found a weight from earlier that year within the GP records and asked that the patient be weighed as soon as possible. The nurse was able to locate a hoist sling and weigh Jacqueline with the recorded weight of 33kg.

The nurse made the decision to administer the lower dose of 500mg on 1st September as they had weighed the patient and had documented the weight of 33kg within the records. Within her statement, the nurse has acknowledged that further action should have been taken on 31st August to alert the medical staff of the need to amend the prescription. A handover should have also occurred when she ended her shift to ensure that the nurse who took over the care of Jacqueline was aware of the fact that Jacqueline was under 50kg and would need a reduced dose of IV paracetamol.

With the introduction of the measures that I have outlined in my response to the Report, the risk of a similar situation occurring again has been mitigated against.

3. Optimisation of Nerve centre information regarding weight accuracy

There is now a prompt when prescribing paracetamol (all routes) on EPMA that reminds prescribers of the need to ensure there is an accurate weight recorded and that the dose is appropriate.

On all IV paracetamol dose sentences for adult patients, it now states 'for IV use – dose as 15mg/kg'. The following message appears on all routes for paracetamol adult dose sentences stating 'Ensure patient weight is recorded as risk of liver toxicity in patients who weigh less than 50kg'. These messages appears at the point of prescribing and administering.

Any weight that is recorded on the system appears at the point of prescribing and administration with a date and time stamp.

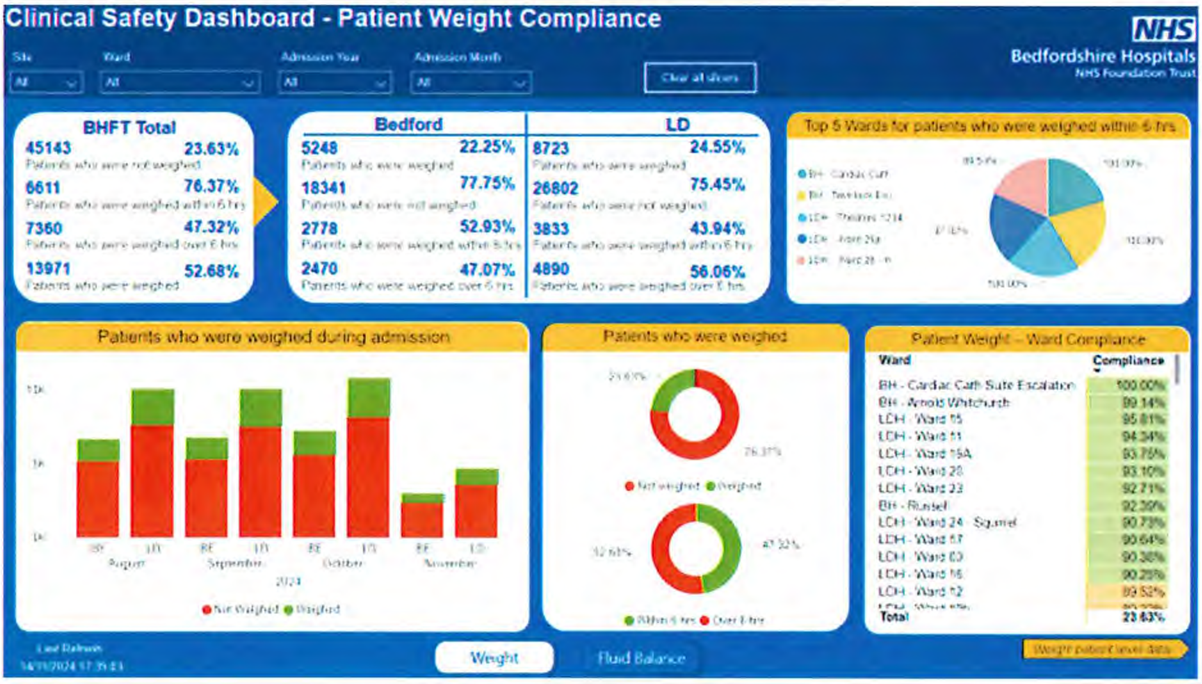
A Nervecentre paracetamol prescribing guide has been produced and been launched in to support safe prescribing of paracetamol.

4. Additional actions related to monitoring weight to reduce risk

All wards have the equipment available to weigh patients on admission. As HSSIB points out in their report, there is more costly equipment available that could make the task easier for nursing staff but are outside of the Trust's available financial resources at present.

What the Trust are trialling is a live dashboard that shows the patient weight compliance for all wards across both hospital sites. Once completed it will be directed towards ward managers and matrons, who at any time will be able to see how many patients have been weighed on a particular ward.

The data provided below is not accurate as the dashboard remains in development at present but the Trust hope that this will be completed before the end of 2025 and will appear as follows:



The data will be taken from the recorded weight on Nervecentre and if a patient has not been weighed within the target time of 6 hours it will reduce a particular wards compliance.

As highlighted within the PSII report, the ward where this incident took place purchased a new pat slide to assist with the weighing of immobile patients. Whilst the purchasing of new equipment can assist in ensuring patients are weighed on admission to a ward, the Trust also recognises the need for there to be IT systems that can support in identifying where a patient has not been weighed and to alert clinical staff so that this can be rectified. This is the aim with the introduction of the dashboard.

Thank you for bringing these important patient safety issues to my attention. I do hope my response provides some assurance to you and Jacqueline's family regarding the actions being taken by the Trust in relation to the care provided to patients who require IV paracetamol but at a reduced amount due to being underweight.

Yours sincerely

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[redacted]

Chief Executive Officer