[redacted]

2nd September 2025

James Paget
University Hospitals
NHS Foundation Trust

[illegible]

Email:s[redacted]
www.jpaget.nhs.uk

Yvonne K Blake
Area Coroner
Norfolk Jurisdiction
County Hall
Martineau Lane
Norwich
NR12DH

Dear Ms Blake

RE: Regulation 28 - Report to Prevent Future Deaths

I am writing to acknowledge receipt of the Regulation 28 - Report to Prevent Future Deaths, issued to the James Paget University Hospital NHS Foundation Trust (JPUH) following the inquest into the death of Miss Susan Young, which was heard and closed on 7th May 2025, and received via our Legal Services Provider on 27th June 2025.

I note your concerns as follows:

During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

*The **MATTERS OF CONCERN** are as follows:*
(brief summary of matters of concern)

No clinical handover to receiving ward.
No instructions passed on from the doctor re cardiac monitoring.
Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose.

The medical cause of death was:
1a) Cardiac Arrest
1b) Mixed Overdose (Including Sertra/ine, Paracetamol and Promethazine)

Circumstances Of The Death
Miss Young was admitted to hospital on 23rd August 2024, having taken an overdose of prescription medication. This was not her first overdose. She was prescribed amongst others Sertraline, Gabapentin and Clonazepam which has the effect of prolonging the Q wave, the heart rhythm. She had taken an overdose on the 22nd August 2024. When this had not succeeded taken another on 23rd August 2024. She was monitored appropriately whilst in the emergency department and transferred to a ward with directions that she be attached to cardiac monitoring.

When nursing staff took her to the ward, they did not give any handover and certainly no instructions about cardiac monitoring. Miss Young was found unresponsive and not attached to any monitoring. Resuscitation failed. It is thought that the medication may have had a cumulative effect. When the nurses were packing up her belongings, they found more unused medication which had been left with the patient. It is not known if she had taken any of this.

The inquest concluded that:
The Patient suffered various cardiac problems, including a previous heart attack. Patient was also prescribed a medication for epilepsy which has the side effect of prolonging the QT interval in the heart rhythm and can precipitate cardiac arrhythmias. Patient was found deceased in bed by nursing staff.

I note that the JPUH was not required to attend the inquest, and we were, therefore, unable to provide clarification regarding these concerns. However, upon receipt of the Regulation 28, an investigation into these matters of concern was commenced.

1. *No clinical handover to receiving ward.*
2. *No instructions passed on from the doctor re cardiac monitoring.*
3. *Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose.*

Our Investigation Findings:

Matters of concern
1. *No clinical handover to receiving ward*
2. *No instructions passed on from the doctor re cardiac monitoring.*

A Patient Safety Incident Investigation (PSII) was conducted regarding Miss Young's case, and the report was shared with you before the inquest. The investigation finding on matters of concern 1 & 2 are reported below.

a) The PSII report included the following statements:

The statements below are copied from the PSI/ report.

The JPUH Patient Transfer and Escort Policy as implemented in March 2023 lays out the standard of in-hours and out of hours internal and external transfer and escort that are required for the safety of all patient groups (Adult, Paediatric, Neonatal - via web/ink and Maternity) who are admitted or being transferred and escorted within or from the James Paget University Hospital. The policy refers to suitable escorts being identified by the use of the risk assessment tool, National Early Warning Scoring system and patient categories levels of care. The need for responsibility and accountability for allocated competent escorts and for those that escort to be competent to escort patients, to be both responsible and accountable whether registered our unregistered staff.

The transfer of Miss Young without a *clinical handover had an impact on both Miss Young and staff caring for her. Reference has been made to the omissions of cardiac monitoring, the hourly observations, and the cardiopulmonary status of Miss Young. If cardiac monitored, it may have picked up* a *treatable rhythm that may have required* a *cardiac shock, therefore the need for clear documentation of the what ifs with Miss Young, as* a *cardiac shock may not have been agreed to by Miss Young, and it doesn't mean that by providing* a *shock this would be successful, considering the prolonged QT, that had already received magnesium as the main treatment to reduce the risk of* a *life threatening arrhythmia.*

Miss Young was *transferred to the Emergency* Assessment *and Discharge Unit (EADU), this transfer occurred without* a *clinical handover, this contributed with an outcome of Miss Young not receiving either hourly observations or cardiac monitoring. It is apparent that Miss Young is transferred to the EADU allocated to* a *bed within the acute visible bay (a bay that allocated patients who require* a *higher need for*

visibility/monitoring), therefore it appears that a handover of source was completed, it's difficult to ascertain if the bay was allocated due to further risk of self-harm or cardiac monitoring or both, although the registered nurse in EADU shares that they were not aware that Miss Young required cardiac monitoring, therefore high probability is that a/location was assigned due to further risks of self-harm.

During Miss Young's attendance on the 23rd of August 2024, she received intravenous medication as advised by Toxbase (clinical toxicology database), this was administered to support a potential prolonged heart rhythm delay (prolonged QT) of which was noted within a tracing of her heart as conducted on the day, further advice was for cardiac monitoring. There appeared to be high risk that Miss Young may experience a life-threatening arrhythmia such as Torsades de Pointes, hence the reason for treatment and cardiac monitoring.

Following Toxbase advice Miss Young is attached to a cardiac monitor within the Emergency Department, it is not apparent from documentation or on speaking with staff as to what they would be observing for by being attached to the cardiac monitor. It is not apparent from nursing staff caring for Miss Young of the risks of a prolonged QT, this is corroborated by Miss Young not being monitored on transfer from ED to EADU.

b) The PSII findings related to the Matters of Concern 1 & 2 are reported below:

There is omission of a clinical handover from EADU to ED through a face-to-face handover considering Miss Young has risks highlighted, such as further self-harm and the need for cardiac monitoring.

The transfer from ED to EADU supervision and engagement assessment is not completed within the Emergency Care Record document, in addition to the non-completion of the transfer checklist.

Action is required on the expectations of a clinical handover from the ED with consideration to the request for visible acute bay on EADU, cardiac monitoring, hourly NEWS recordings and the risk of further self-harm.

The medical plan agreed is for intravenous fluids, a blood sugar check, to start Intravenous N-acetylcysteine (NAG) (medication to treat paracetamol overdose), to prescribe and administer magnesium 2 grams intravenously (is the first line of treatment for severe QT prolongation), for cardiac monitoring, bloods and a venous blood gas and to refer to the medical team.

The actions as documented within the plan are followed and implemented, this includes the prescribing and administering of magnesium 2 grams intravenously (magnesium sulphate is the first line treatment for severe QT prolongation, even if the levels are normal and is administered to prevent Torsades De Pointes (TOP), magnesium reduces the risk of arrhythmias. It also helps in slow heart rates such as bradycardia and therefore reduces arrythmia risk even when bradycardia is the primary cause) the request for cardiac monitoring, both to support the prolonged QT with referral to the medical team.

Following Toxbase advice Miss Young is attached to a cardiac monitor within the Emergency Department, it is not apparent from documentation or on speaking with staff as to what they would be observing for by being attached to the cardiac monitor. It is not apparent from nursing staff caring for Miss Young of the risks of a prolonged

QT, this is *corroborated by* Miss *Young not being monitored on transfer from ED to EADU.*

Miss *Young* is *omitted to receive cardiac monitoring whilst an inpatient on EADU* as *requested*

The transfer of Miss *Young without* a *clinical handover had an impact on both* Miss *Young and staff caring for her. Reference* has *been made to the* omissions *of cardiac monitoring, the hourly observations, and the cardiopulmonary status of* Miss *Young. If cardiac monitored, it may have picked up* a *treatable rhythm that may have required* a *cardiac shock, therefore the need for clear documentation of the what ifs with* Miss *Young,* as a *cardiac shock may not have been agreed to by* Miss *Young, and it doesn't mean that by providing* a *shock this would be successful, considering the prolonged QT, that had already received magnesium* as *the main treatment to reduce the risk of* a *life threatening arrhythmia.*

There is *omission of* a *clinical handover from EADU to ED through a face-to-face handover considering* Miss *Young* has *risks highlighted, such* as *further self-harm and the need for cardiac monitoring.*

If ***my mum had received cardiac monitoring could any intervention have occurred to reduce the risk of my mum's heart stopping.***
This question was *asked of the lead cardiologist who shared that if cardiac monitoring* was *in place prior to* Miss *Young's death, it potentially may have picked up* a *rhythm that may have triggered further specialist discussion* as *to next* steps, *with* Miss *Young being at the heart of the discussion.*

Discussion may have included the most *appropriate place to monitor* Miss *Young, considering the high risk of* a *life-threatening arrhythmia such* as *Torsades de Pointes. Prior to cardiac arrest* a *treatable rhythm may have been identified, this may be* a *rhythm that required* a *controlled cardiac shock; therefore, the understanding of the what ifs are so important for Miss Young, considering that* she *wished not to be for resuscitation of which includes* a *cardiac shock.*

Miss Young had received treatment for prolonged QT,· IV magnesium as *administered in ED to reduce the risk of* a *life-threatening arrhythmia. The staggered additional prescribed medication overdose may have lengthened the QT further considering the QT was within normal range in June 2024.*

Following the toxicology of blood samples there were traces of concentrations of Paracetamol and Promethazine were detected along with therapeutic concentrations of Sertraline, Gabapentin, and Codeine. Full interpretation of these findings should consider the time between ingestion, hospital admission and death. Paracetamol should be interpreted along with findings from liver histology. There has *been prior Clonazepam use. Roxithromycin, Atorvastatin, Bisopro/ol and Loperamide were* a/so *detected.*

c) The PSII Actions and their status shared with you prior to the inquest: (an update on the progress of the actions is reported in section e)

Safety Action Summary Table

(W)□ = Not yet started (G)cua= Gompleted (A)m!w;= In progress

ID	L_lamlng Idenlifi□lion Required	R□pon□ility	Timescale	RAG	Comments/Evidence of Achievement/Reason for Slippage
D	**Le.iming Identified - The expectations of a clinical handover from the ED with consideration to the request for visible acute b.iy on EADU, c.irdlac monitoring, hourly NEWS recordings and the risk of further self-harm.**				
D1	**Action Required - Local** To complete the Emergency Care transfer safety checklist as seen within the Emergency Care record, to support safe transfer of patients from ED to EADU, by relaunching the safety checklist with registered nurses in Emergency Care.	[redacted] Clinical Educator ED	30th July 2025	A	
D2	**Action Required - Local** To include the patient transfer policy as part of the relaunch that highlights within, the transfer escort checklist, if one or more of the following apply to this patient then an escort is required this includes any **patient that causes concern** as in this scenario.	[redacted] Clinical Educator ED	30°' July 2025	W	

[redacted], Deputy Lead Nurse, Division of Medicine, Diagnostics & Clinical Support Services provided a statement for the inquest on the 27th of May 2025. The statement provided added information and assurance around the actions being undertaken.

d) Statement Content regarding Actions D1 and D2

Action D1 - *To complete the Emergency Care transfer safety checklist as seen within the Emergency Care record, to support safe transfer of patients from ED to EADU, by relaunching the safety checklist with registered nurses in Emergency Care.*

Action D2 - *To include the patient transfer policy as part of the relaunch that highlights within, the transfer escort checklist, if one of the following apply to this patient then an escort is required this includes any **patient that causes concern** as in this scenario.*

i. I can confirm that the Clinical Educator has completed transfer training at the ED educational away days, which included training on the transfer checklist within the emergency care record documentation and the patient transfer and escort policy. These were held on the 4th and 9th April and the 7th and 16th May 2025. 68% of the current ED nursing and support staff attended. In addition, the Clinical Educator circulated the patient transfer and escort policy and the transfer checklist to all staff via email. Those who were unable to attend the away days due to sickness or maternity leave will attend a bespoke training session at the earliest opportunity. A signatory list will be commenced to ensure all ED nursing staff have read and understood the policy and checklist.

ii. The training reviewed the patient transfer and escort policy and included information regarding internal and external transfers. This highlighted the importance of effective communication between the transferring and receiving department and undertaking the risk assessment tool within the policy to determine who should transfer the patient. This will ensure specific information such as cardiac monitoring is handed over in future.

iii. Whilst the remaining staff are captured in the bespoke training sessions, the Clinical Educator will complete safety checklist compliance audits monthly to provide assurance that the process is embedded. This audit is in the planning phase; however, it is anticipated this will enable the team to monitor compliance, identify any gaps and support the team with any additional training needs.

iv. EADU nursing leadership have supported staff to complete safety huddles following this incident, which included information about this incident, initial learning including the requirement of a nurse escort when clinically required. Additionally, staff escalate to the Nurse in Charge on EADU if they have any clinical concerns about patients who are transferred from ED, the Nurse in Charge will discuss this with the ED nurse in charge to gain further information about the patient. A QSAFE incident is completed if there are concerns about patient transfers and learning from these incidents is shared with the teams.

v. A three month historical search of QSAFE has identified no further concerns regarding transfers from ED to EADU. QSAFE incidents are reviewed daily by the matron team via the matron safety huddle and subsequently at the Trust's daily incident triage meeting, with escalation to the safety action and assurance group (SAAG). Any themes and trends are escalated through the relevant insight group and learning is supported by the division and the corporate nursing team.

vi. As a Trust, we are developing a communication process for handover with a task and finish group commencing 23rd May 2025. This includes leads from each department including ED and EADU. The flow chart is in the design phase, with an aim to commence the new process mid-June. Specialist requirements for the patient including cardiac monitoring will be included in the handover template. Once embedded, an audit will take place to monitor compliance and identify gaps needing further education and support.

e) Reporting of the current status of the actions D1 and D2

Safety Action Summary Table

(W)!llm = Not yet started | (GII,.m= Completed | (AJmlw;=. In progress | (R)ed = Due but not complete | (B)lue = Ongoing monitoring to be assured of continued achievement

ID	□ea□In□Identified/ Ac1ion Required	Respo_llslblity	Tlmescale	RAG	_Com□nts/Evldonce of Achlevemen1/Reas□ for Slippage
D	Leaming Identified. The expectations of a clinical handover from the ED with consideration to the request for visible acute bay on EAOU, cardiac monitorin11, hourly NEWS recordin11s **and** the risk of further self.harm.				
01	Action Required - local To complete the Emergency Care transfer safety checklisl as seen within the Emergency Care record, lo support safe transfer of patients from ED to EADU. by relaunching the safety checklist with registered nurses in Emergency Care.	[redacted] Clinical Educator ED	30"' July 2025	G	The Senior Nursing Team have shared during hol topics which lake place at handovers day and nighl to ail staff within ED the importance of completing a ltansfer checklist and how lo complole. Clinical Educator has provided addilional teaching to workforce and how they can support with compleUon of a transfer checklist. A learning board has been completed on 20th January showing staff how to correclly fill in the Emergency Care record 
DZ	**Action Required** . **Local** To include the patient transfer policy as part of lhe relaunch lhat highlights within, lhe transfer escort checklist, if one or more of the following apply to this patient then an escort is required this includes any patient that causes concern as in this **scenario**.	[redacted] Clinical Educator ED	30[111] July **2025**	**G**	Clinical Educator transfer \raining completed at ED educational **away** days (register **al1ached**). Internal risk assessmenl tool for transferring **a** paUent shared. **Key** poinls from transfer policy shared with slaff. Pocket size cards laminated and shared with staff. tHm away day 7th May registe.pdf · Teilm Awry Oay□h April register pdf · team away dap Apr3 registeq:,df · 4hfl · il'Jr.sft• g-:,id.aD::llmg

f) Evidence of completion of actions D1 and D2 of the PSII action plan

Action D Evidence	Attachments
Clinical Educator transfer training completed at ED educational away days (register attached).	7th May away day register.pdf 9th April away day register.pdf 4th April away day register.pdf
Internal risk assessment tool for transferring a patient shared.	Transfer guidance.msg
Key points from transfer policy shared with staff.	
ED Patient Handover Form now in use	ED SBAR Handover 2025.docx

Matter of Concern

3. ***Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose.***

a) The PSII report included the following statements related to Matter of Concern 3:

The statements below are copied from the PSI/ report.

There are documented risk checklists evident within ED for those patients attending with self-harm, in addition to further risk assessments evident within the emergency care record for those patients being admitted to an inpatient bed.

Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose.

Strips of medications were found within Miss Young's property following her unexpected death.

In that medication bag contained 20X full strips of X6 loperamide, 3 strips of 10 loperamide + one empty strip of 10 tablets. 2x empty strips of 6x loperamide, 3x strips of 10 tablets of zapain 301500mg with 3 tablets missing.

It is unclear how this was missed when the HCA was doing the property list. 2X bags of medication were locked in the locker, we cannot be sure nothing else was taken on the ward.

The patient was in a visible bay and all staff informed of the ligature risk. observations were taken at 16:50 stable. The clerking notes do state that it was not just a paracetamol OD it was multiple drugs, and patient had a prolonged QT and the plan states cardiac monitor which patient was not put on, the patient had NAG in place.

b) The PSII findings related to Matter of Concern 3 were.

JPUH Self Harm Policy
This policy and procedure as implemented in March 2024 provides clear guidance to staff in relation to providing a safe environment for a patient who is at risk of self-harm. This includes the assessment of the risk and the management of the patient and guidance on the removal of items from the patient environment which could be used to self-harm.

The National Institute of Health and Clinical Excellence (NICE) have published a Self-Harm Quality Standard Number 34 (NICE 2022) and Clinical Guidance 225 (NICE 2022). This policy does not replace the responsibility of all staff involved to apply NICE quality standards and clinical guidance appropriately.

There appears to be no evidence of consideration of the level of enhanced supervision or to environmental risk i.e. medications, especially as property listed belonging to Miss Young following her death contained strips of both used and unused medications.

The need for staff to comply and adhere to the self-harm policy to support patient safety

To clarify expectations of a clinical handover from the ED with consideration to the request for visible acute bay on EADU, cardiac monitoring, hourly NEWS recordings and the risk of further self-harm.

c) The PSII Actions and their status shared with you prior to the inquest: (an update on the progress of the actions is reported in section e)

(W) = Not yet started **(G)Wm** = Completed **(A)** = Inprogress

ID	Leaming identified/ Action Required	Responsibility	Timescale	RAG	Comments/Evidence of Achievement/Reason fo Shppaae
C	**LearningIdentified** - **Trust Wide** - To comply and adhere to the self-harm policy to support patient safety				
C1	**Action Required** - **Local** To complete the agreed process for searching patients to maintain patient safety (this will form an addendum to the self-harm policy	[redacted] Matron Mental Health Liaison Team& [redacted] D Consultant	30th June 2025	**A**	
C2	**Action Required** - **Local** To share the self-harm policy across Emergency Care with a reference to this patient safety incident once the addendum as above has been added.	[redacted] Matron Urgent Care	30th July 2025	W	

d) Statement Content regarding Actions C1 and C2

i. Action C1 - To complete the agreed process for searching patients to maintain patient safety (this will form an addendum to the self-harm policy.)

I can confirm that the Trust's Self Harm Policy (copy attached) now includes an addendum (Appendix C) an SOP (Standard Operating Procedure) Search of Patients within the ED. The policy describes the rationale behind searching patients attending the ED in Mental Health crisis to reduce the risk of patients attempting further overdose or self-harm during their time in the ED. The updated policy has been uploaded to the Trust's intranet.

ii. Action C2 - To share the self-harm policy across Emergency Care with a reference to this patient safety incident once the addendum as above has been added.

I can confirm that the search policy has been shared with all ED clinical staff on the 16th April 2025 and was added to the self-harm policy as an addendum which is available on the intranet for all staff to access. Following this, a signatory list will be collected to ensure that all staff have read and understood the policy and its implications for patients presenting with self harm.

e) Reporting of the current status of the actions C1 and C2

(W) = Not yet started (G) -=Completed (A = In progress

	Learning identified/ Action Required	Responsibility	Timescale	RAG	Comments/Evidence of Achievement/Reason for Slippage
	Learning Identified - Trust **Wide** - To comply and adhere to the self-harm policy to support patient safety				
C1	Action **Required** - Local To complete the agreed process for searching patients to maintain patient safety (this will form an addendum to the self-harm policy	[redacted] Matron Mental Health Liaison Team & [redacted] ED Consultant	30th June 2025	G	Self Harm Policy attached which includes addendum 'fu!eSearch of Patients within ED' (Appendix C) and has been uploaded to the intranet Self Harm Policy V3 04.2025.doc
C2	**Action Required - Local** To share the self-harm policy across Emergency Care with a reference to this patient safety incident once the addendum as above has been added.	[redacted] Matron Urgent Care	30th July 2025	G	[redacted] has emailed SOP to ED, EADU and Ward 16. Self harm - additional SOP .ms

f) Evidence of completion of actions C1 and C2 of the PSII action plan

Action C evidence	Attachments
Self Harm Policy attached which includes addendum 'SOP Search of Patients within ED' (Appendix C) and has been uploaded to the intranet.	Self Harm Policy.doc
Self Harm Appendix C - Standard Operating Procedure Search of Patients within the ED..	LJ Self harm - ED additional Self Ham

Conclusion and Next steps:

For matters of concern,

1. ***No clinical handover to receiving ward.***
2. ***No instructions passed on from the doctor re cardiac monitoring.***

We have identified Ward Transfer and Handover as an important Patient Safety Issue in the trust for action. There has been significant action achieved and ongoing.

This has been highlighted at the Trust Patient Safety Improvement Group and have discussed and agreed actions to address the issues identified , the group is receiving ongoing update and assurance reporting, which will include audit results going forward.

It is evident that there was a medical plan in place for cardiac monitoring, identified during ED medical assessment and the clerking of the patient for admission completed in ED. Cardiac Monitoring was in place in ED. However, this requirement was not handed over via the clinical handover process between ED and EADU nursing staff. The patient was already clerked for admission by the medical registrar but sadly the patient passed away before her next medical review on EADU.

The Emergency Department Clinical Educator has completed Transfer Training for ED at the ED educational away days, this included focussed training and update on the Trust Patient Transfer and Escort Policy, regarding internal and external transfers, the use of the ED transfer checklist, and the Emergency Care Record documentation requirements.

The training highlighted the importance of effective communication between the transferring and receiving department and undertaking the risk assessment tool within the policy to determine who should transfer the patient. This will ensure specific information such as cardiac monitoring is handed over in future. It is currently being promoted as an ED hot topic at all handovers in ED.

For matters of concern,

3. ***Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose.***

The updated Trust Self Harm Policy now contains the addendum 'Standard Operating Procedure Search of Patients within the ED'.

This procedure describes the rationale behind searching patients attending the ED in Mental Health crisis who are deemed to be medium to high risk of harm to themselves or others. It lays out in detail eight points for staff to follow including, *Point3, "Patient's bags and clothing should be checked for medication, sharp objects and potential ligatures. These should be removed and kept in* a *safe place within the ED, clearly labelled with the patient's name."*

The purpose of this SOP is to reduce the risk of patients attempting further overdose or self-harm during their time in the ED with items that they have brought into the department with them. Sadly, this was not fully completed in Susan Young's case. Promotion of this SOP has been undertaken for all staff in ED, including send ED staff a copy of the updated Self Harm Policy and ED search of patients SOP. Face to Face promotion has been supported by our Mental Health Liaison Matron and the lead nursing staff in ED. We acknowledge there was a gap in monitoring of this element which we are ensuring is addressed.

To support and evidence our addressing of all three matters of concern raised, we have included the updated Trust Transfer Policy, including the trust handover process which has been communicated and promoted to staff, the summary of the policy expectations that has been communicated to ED staff, evidence of the associated staff training undertaken and a copy of the ED Patient Handover Form now in use for all patient transfers. An audit of the implemented ED Patient Handover Form is scheduled in September and will be ongoing monthly until results demonstrate good and consistent compliance.

Evidence of the updated Self Harm policy and addendum of Standard Operating Procedure Search of Patients within the ED and evidence communication of this to ED staff which has been supported by a signing list has been included in our response.

I trust that this adequately addresses the concerns raised in the Regulation 28 Report. However, should you require any further clarification regarding this, or any other case, please do not hesitate to contact the Trust.

Yours sincerely

[redacted]
Executive Managing Director