The Princess Alexandra Hospital
NHS Trust

Hamstel Road
Harlow
Essex
CM20 1QX

Private and Confidential

Area Coroner Sonia Hayes
Essex Coroner's Court
Chelmsford County Hall
Victoria Road
Chelmsford
CM1 1QH

8th January 2026

Dear Coroner Hayes,

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

I write in the matter of the late Paolino Amico in response to your recent Regulation 28 Report to prevent future deaths which was issued on 17th November 2025.

Mr Amico was admitted to Princess Alexandra Hospital on 14th May 2024 complaining of shortness of breath and productive cough. He had a medical history of metastatic urothelial carcinoma and had received experimental treatment at Barts Hospital however this had been discontinued due to disease progression. CT scan on admission identified dramatic progression of pulmonary metastatic disease since a previous CT scan in January 2024. There was no pulmonary embolism.

He was treated with oxygen, nebulisers, fluids and antibiotics. His oxygen requirements during admission were 2 litres reducing to 1litre.

Following discussion with the family a Do not resuscitate form was signed. A discussion was had with the family regarding any further treatment such as chemotherapy. The oncology consultant advised the family that Mr Amico was unable to have chemotherapy whilst on oxygen. It was discussed that attempts to wean Mr Amico off oxygen would be attempted.

Mr Amico was discharged home on 29th May 2024 with referral to the community palliative care and home oxygen. Unfortunately, he was readmitted to Princess Alexandra Hospital on 9th June 2024 with community acquired pneumonia and died on 12th June 2024.

I note the eight areas of concern which you have raised and will respond to in turn.

1. **The consultant required a discharge plan for oxygen therapy to be in place before Mr Amico could go home.**

   The hospital discharge plan and medications were confusing and the referral for oxygen therapy requirement was unclear

   PAT testing for the machine was out of date.

   Paramedics advised the family that the oxygen provided on Mr Amico's discharge was low flow and was not meeting his oxygen requirements with his oxygen saturations at 68% and this immediately improved on ambulance crew equipment.

On the 28th May 2024 Mr Amico was assessed by the respiratory Clinical nurse specialist with Mr Amico's daughter and the following plan was agreed. He was assessed as requiring home oxygen, nebulisers, analgesia and review of the dietician when at home. At the time of assessment Mr Amico was requiring 1litre of oxygen per min via nasal cannula. His oxygen saturation level was 89%

The respiratory clinical nurse specialist completed an order form for home oxygen requesting the following:

- 2 static concentrators to provide 1litre of oxygen per min via a nasal cannula for 20-22 hours per day.
- 4 Standard ambulatory cylinders to provide 1litre of oxygen per min via nasal cannula for 1-4 hours a day

The equipment was delivered and installed to Mr Amico's home address on 29th May 2024 by BOC gases the company who supply home oxygen, prior to his discharge.

Portable Appliance Testing (PAT) is a process used to ensure the safety of electrical appliances and equipment. The head of patient services at BOC has informed our operations team that they do not PAT test concentrators as there is no legal requirement for them to be PAT tested.

Our operations team report that the concentrator had likely been PAT tested when it had been previously provided to a care home as part of their legal requirements.

BOC have confirmed that they will ensure any stickers are removed from any concentrators being returned prior to leasing them out again and apologise for any confusion.

The discharge plan included a referral to the community respiratory team to monitor oxygen, district nursing for medication review and Specialist palliative care team

(SPCT) and to Isabel Hospice. Referral was completed on the 29th May 2024.

The comments from the paramedics relate to Mr Amico's oxygen requirement at the time they assessed him. At the time of discharge the respiratory nurse had assessed Mr Amico and his oxygen requirements based on an evidence-based assessment and the appropriate level of oxygen based on those observations was prescribed and arranged for him at home.

2. **Mr Amico did not receive his prescribed medications during his second admissions when he was readmitted to hospital on 9 June.**

    a. **On 9 June a doctor in Accident & Emergency had reviewed Mr Amico's prescribed medications and increased liquid oral morphine sulphate 10 mg in 5mL Solution 4 hourly as required with 2.5 -5 mg max 6 doses at 22:57 hours with slow released morphine sulphate (MST) continued 2 times daily. Trust staff did not administer any morphine to Mr Amico although he and his family were raising concerns about his high level of pain.**

Mr Amico was admitted to PAHT on 9th June 2024 at 17.21and he was triaged by advanced clinical practitioner (ACP) at 18.26. At 18.50 he was reviewed by a FY2 doctor and referred to the medical team.

He was reviewed by the medical clinician at 21.33 and no account was taken that he had not received his 8pm MST dose.

On 9th June 2024 at 22.58 Morphine Sulphate (MST) modified release was prescribed for twice daily at 08.00 and 20.00. Oramorph was also prescribed as required (PRN).

    b. **The family was informed incorrectly that medications had not been prescribed. On the morning of 10 June, the family were given permission by a nurse to dispense from Mr Amico's own supply of medications that he had brought to the hospital due to his level of pain. This was not accurately recorded in Mr Amico's record. Mr Amico took his prescribed morning dose of MST.**

On 9th June 2024 at 22.58 Morphine Sulphate (MST) modified release was prescribed for Mr Amico twice daily at 08.00 and 20.00. Oramorph was also prescribed PRN.

The emergency department do not have a stock of MST. At the time there was not a patients' own controlled drug book to record controlled medication. The administration was recorded on JAC, the Trust electronic medication system that his family had given his regular prescribed medication.

As part of the learning from this incident a patients' own controlled drug book has now been introduced in ED to ensure that this is recorded and accounted for within the department.

c. **On 10 June the nurse in the emergency department did not escalate to the nurse in charge or a senior doctor that she could not locate the doctor allocated to Mr Amico and instead approached a foundation year 1 doctor to prescribe pain relief for Mr Amico. The nurse asked the doctor who was junior and very busy that the frequency of the morphine needed to be increased for Mr Amico. The doctor did not escalate the matter and did not review Mr Amico before prescribing a controlled drug.**

A Multi-Disciplinary After-Action Review meeting was held, including staff involved in the incident. This identified learnings and actions to be taken. It established that the ED nurses looking after Mr Amico had been redeployed from another ward so were not fully aware of the ED escalation process that occurs in the emergency department.

As part of the learning following the after action review the escalation process with nurses redeployed from base ward to other areas need to be included as part of the orientation specific to the area they are redeployed to.

Further learning was discussed in regards to doctors: regardless of seniority, they must take responsibility when approached by nurses to review a patient. If they acknowledge the patient is not under their care and a nurse is unable to locate the appropriate doctor, they must escalate to the nurse in charge (NIC). Once a doctor has agreed to review a patient they should review the relevant background and assess the patient face to face.

The doctor who changed the prescription reviewed the incident with his educational supervisor and as part of his reflection acknowledged that he would take the responsibility to not alter any the treatment without at least reviewing the patient first.

d. **Neither the nurse nor the doctor sufficiently scrutinised the medication prescribed on 9th June on the Trust system that would have shown the correct medications. This led to a prescription error being made with MST being increased from 2 times daily to 4 times daily. Mr Amico was not referred for pain management.**

Mr Amico's regular MST was modified to 4 hourly. Modifying an existing prescription bypasses the medication clinical support (MCDS) attached to EPMA (Electronic Prescribing & Medications Administration system), as well as any warnings or additional information. We have now removed the modify option to prescriptions (this was done first on our previous EPMA system, and has continued onto Cerner/AlexHealth).

What this means is that to change a prescription, a doctor would have to either click 'cancel/reorder' or 'discontinue' the drug and add a new drug to the system, both of which would force the prescriber into acknowledging any warnings and overriding any interactions picked up by the MCDS.

In addition, we have recognised there is a huge variation in morphine formulation and type and have made the naming of products clearer. For example, MST is noted as 'Morphine MODIFIED RELEASE 12 HOURLY tablets on the system. We have also pre-defined the frequency as twice a day.

If the same prescription was to be changed today, it would bring up warnings about formulations of opioids, have the frequency predefined as twice a day, and the MCDS would flag to the prescriber that morphine sulphate oral solution is already prescribed.

This brings in an additional layer of clinical review and judgement, guiding the prescriber to select an appropriate medication. For all modified-release preparations of morphine, this list labels them as '12 hourly preparations' and pre-loads the frequency as twice a day.

e. **Mr Amico then moved to a ward. Multiple nurses were involved in checking and administering a controlled drug morphine sulphate slow release (MST) on 5 separate occasions between 10 and 11 June 2024 and did not raise concerns about the potential for a prescription error or note that Mr Amico had already received 1 dose of MST that morning.**

The Trust acknowledged that the medication administration error occurred and this was discussed with the staff involved through the following actions:

An after action review meeting took place on 26th June 2024 and included:

- Associate Director for Governance and Quality – Chair
- Doctor involved in prescribing the MST
- Acute Medicine Clinical Lead (to support doctor involved)
- Nurses involved in administration
- Matron for Medicine Division (to support nurses involved)
- Lead Professional Nurse Advocate
- Medication Safety Officer
- Patient Safety & Quality Leads – Medicine and Urgent & Emergency Care

Restorative clinical supervision took place in June 2024, which was a reflective discussion with special emphasis on how to manage challenging prescribers and how to have an effective professional discussion when in doubt of management plan, and how to escalate higher if still in doubt.

Ward Practice development team carried out a professional nurse advocate session, completed in June 2024. This included a review of controlled drugs and their frequencies, palliative care and controlled drug frequency changes, importance of clear communication and escalation when patient's Early Warning Score changes.

Monthly ongoing meetings with ward matron and chief pharmacist and EPMA lead to review all incident themes for ongoing monitoring.

Learning was shared across the Divisions and Trustwide by the Patient Safety and Quality (PSQ) Lead Nurse and discussed at Medicine Divisional Governance meeting and learning from deaths group.

3. **Mr Amico's NEWS score increased, and an emergency call was not put out on 11 June when it was established that Mr Amico was unresponsive even to pain from 03:00 hours.**

The Trust acknowledges there are discrepancies with the medical records documentation around the period of the 11th June.

From the observation records and medication chart, Mr Amico's NEWS score at 01.47 was 3, at 05.25 MST was given to Mr Amico which consists of an oral tablet being given and swallowed.

At 06.46 Mr Amico's NEWS score increased to 10. This was escalated to hospital @night, CCOT and Nurse in charge. It was at this time the family raised concerns regards to the MST being given 4 hourly instead of Oramorph

It is noted that the documentation from the doctor who reviewed Mr Amico suggests that Mr Amico had been unresponsive since 3 am however the Trust is unable to ascertain where this information came from as the observation and medication records do not corroborate that finding.

There were no concerns raised around 03.00 am that Mr Amico was unresponsive or that his condition had deteriorated at that time. If that had been the case then his deteriorating condition would have been escalated to the OOH team.

If there had been any concerns around him being unresponsive at 05.25 when he took the further dose of MST, escalation would have occurred at that time.

4. **The on-call doctor was called approximately one hour after Mr Amico's NEWS score was found to be 10 and arrived at 07:50, this was not an emergency call. The on-call doctor had not been informed of:**

a. **the deterioration in Mr Amico's presentation during the night**

The hospital at night team were contacted following the raised NEWS score of 10 at 06.46 and attended immediately. The doctor was told by the family that Mr Amico had been unresponsive since 3am, however medication had been taken by Mr Amico at 05.25.

Blood gas recording was at 07.30.

b. **that the family had informed nursing staff of their concerns Mr Amico had been given the wrong medication when he was noted to be unresponsive at approximately 03:00 hours, that should have immediately raised concerns about an overdose of MST.**

According to the nursing records it was at 06.46 when Mr Amico was found to be drowsier when his relative asked what medication he was being given through the night and questioned why he had been receiving MST every 4 hours as he only took it twice in 24hours at home.

5. **The on-call doctor escalated concerns immediately but no emergency call was put out.**

An emergency call was not required at that time as all appropriate care was initiated promptly.

6. **Mr Amico morphine overdose was partially treated:**

a. **There was an immediate response to Naloxone but the opioid reversal for overdose was not in accordance with British National Formulary guidelines or with an NHS England alert previously issued.**

The prescription of Naloxone was incorrect; it was prescribed in line with acute overdoses and not for patients on long-acting chronic therapy. There is prescribing guidance in the BNF, and in the prescribing alert (first released in 2014, and rereleased in 2019). Appendix 1

The BNF highlights that doses used in acute opioid/opiate overdose may NOT be appropriate for the management of opioid/opiate induced respiratory depression and sedation in those receiving palliative care and in chronic opioid/opiate use. The recommended dose for adults in post-operative respiratory depression and for palliative care and chronic opioid/opiate use by intravenous injection is 100 to 200 micrograms (1.5 to 3 micrograms/kg). If the response is inadequate, give subsequent dose of 100 micrograms every two minutes. Even where doses are given as recommended, there is still a need for careful monitoring of vital observations and maintaining or restoring pain relief.

This has been shared by the palliative care team at educational events. The Medication Safety Officer is also liaising with the EPMA team to see how we can utilise AlexHealth to inform prescribers/safeguard against a repeat.

We have also had two ICS/PAH collaborative events around opioids for grand round (one in November 2024, another booked for February 2026).

The Trust also has a policy on Naloxone, which was reviewed following this incident. see Appendix 2.

b. **There was no consideration or plan for alternative pain management in a patient who had been receiving morphine pain relief as part of his treatment plan for cancer.**
c. **Mr Amico suffered acute withdrawal syndrome and family complained about his suffering to hospital staff that they stated was not ameliorated. An emergency call would have triggered the attendance of an**

Anaesthetist who could have given advice on opioid reversal in a palliative patient.

It is documented in the hospital records that Mr Amico was reviewed by a palliative care consultant on 11th June 2024 at 10.10am and a plan was discussed with the family regarding starting midazolam for agitation and alfentanil via a syringe driver for pain.

On 11th June 2024 at 13.00 Mr Amico was reviewed by an CT3 anaesthetist and the plan regarding the Naloxone infusion was discussed with the ITU consultant who agreed the plan. On 12th June at 03.00 Mr Amico seemed agitated and haloperidol 1mg was given followed by a further dose. Agitation subsided.
Mr Amico was prescribed S/C morphine (2.5mg every 4 hours if needed) after the MST, but none was administered.

7. **Multiple nurses were involved in morphine administration, and all had completed their original training outside of the UK and had undertaken a Trust medicines administration training that should have recognised the prescription of MST 4 times a day was not appropriate. Mr Amico received 6 doses of MST in less than 24 hours instead of 2.**

All nurses involved in this case were internationally trained and, upon joining the Trust, undertook medicines administration training in line with NMC standards. This training is currently designated as **essential** within PAHT, meaning it is compulsory for staff in roles requiring it. Responsibility for completion lies with the individual and their line manager, and compliance is monitored through the Trust's TiMS system and appraisals.

The medicines administration training includes key topics such as general medicines management, insulin administration, antimicrobial resistance, and controlled drugs. It is intended to ensure safe prescribing and administration practices. Despite this, the error occurred, resulting in Mr Amico receiving six doses of MST within 24 hours instead of the prescribed two. This indicates a failure in the application of training and highlights the need for strengthened competency assurance.

The Trust is reviewing this incident under its governance processes and considering additional measures, including enhanced training and monitoring, to prevent recurrence.

8. **Medicines administration refresher training for nurses is not mandatory and the Trust in reviewing this case has not followed a local recommendation from senior nurses for this to be included.**

Medicines administration refresher training is currently **not mandatory** at PAHT. Initial training is classified as essential, but refresher

courses are not systematically required or monitored. Senior nursing staff previously recommended that refresher training be included as part of ongoing competency assurance; however, this recommendation has not yet been implemented.

The Mandatory Learning Oversight Group (MLOG) is actively reviewing the training framework, including whether medicines management training should move from **essential** to **mandatory** status. If adopted, this would ensure refresher training is tracked, monitored, and reported at governance level. The Trust acknowledges this gap and is considering changes to strengthen compliance and patient safety. Mandatory training is defined by NHS England as statutory (legal requirement) and NHS mandatory (NHS Core Skills Framework). This is still the responsibility of the individual and line manager to complete but is monitored and reported via PAHT governance and NHSE.

In 2023 PAHT confirmed Medical Gases training could be mandatory. Currently 2216 staff including 630 staff in Medical and Dental staff group have Medical Gases on their profiles as Mandatory training.

I hope this letter helps address the concerns raised in your Regulation 28 notice for prevention of future deaths.

Please do not hesitate to contact me if you require any further details.

Yours sincerely

[redacted]

[redacted]
Chief Medical Officer