East Sussex Healthcare
NHS Trust

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Dear Ms Redman,

East Sussex Healthcare Trust Response to Regulation 28 Report – David Joseph Dugdale

Thank you for your letter of 8th January 2026, enclosing your formal report under Regulation 28 to Prevent Future Deaths you made at the conclusion of the Inquest into Mr David Joseph Dugdale's death on 19th May 2024 (Inquest concluded on 21st November 2025). I would like to convey my sincere condolences to those who knew and cared for Mr Dugdale and would like to assure them that we have considered all the recommendations in the report and have made changes to our systems as a result.

The Prevention of Future Deaths report identifies the following areas of concern, and we address each one in turn with our findings and actions that we have undertaken, or plan to undertake.

1. **Poor management of David's pain. In spite of sustaining a category 2 pressure sore and bilateral hip fractures whilst an inpatient at EDGH, he was only receiving oral paracetamol. Not until ambulance crew raised their concerns about his inadequate pain relief prior to their transferring him to Conquest Hospital did he receive increased and more appropriate pain relief. His carers repeatedly tried to advise nursing staff that he was in pain, but their concerns were not listened to nor acted upon.**

   We recognise that Mr Dugdale did not receive adequate pain relief and recognition of pain in non-verbal, vulnerable, and learning-disabled patients was not of a standard we expect, in response, the following measures are to be implemented immediately. On admission clinical teams are to liaise directly with family members and carers to establish how the patient typically expresses pain and what interventions have previously been effective. "This is Me" documentation is requested to support the multidisciplinary team in understanding the patient's individual needs. All patients who are unable to reliably self-report pain receive a structured pain assessment at least once per shift, using the learning disability pain tool and incorporating carer or next-of-kin input, with care-home documentation used where available. Any unresolved pain following simple analgesia, or pain reported by carers, triggers a same-shift senior nurse review and medical escalation. In addition, the Learning Disability Nurse completes and documents a specialist review within 48 hours of admission for all patients with a learning disability.

   Medical teams will incorporate a daily pain checklist, including review of the learning disability pain tool, EPMA, diagnostics, and radiologic, to ensure ongoing pain control and

timely intervention. Care plans are to be adjusted based on the patient's response to analgesia, with clear and concise documentation. Regular communication is maintained between medical teams, nursing staff, carers, next-of-kin, HCAs, and the Pain Team to ensure optimal pain management. For patients with fractured hip, neck of femur, or long-bone injuries, pain management should be initiated immediately and without delay, including Iliofascial Nerve Block by trained clinicians in addition to Morphine, Buprenorphine patch, intravenous paracetamol etc. unless contraindicated. Orthopaedic teams will provide prompt review across both sites, and transfers from Eastbourne District General Hospital to Conquest via ambulance will require a completed a neck of femur fracture pain checklist to ensure adequate pain control prior to movement. Definitive pain management of fractured neck of femur/long bones will be under the Orthopaedic team (surgical management) and a Safety Pin (attachment A) has also been circulated to share learning across divisions and reinforce expectations.

To provide assurance of sustained improvement, monthly audits of pain assessment documentation and escalation actions are now in place with the first audit scheduled within three months. Audit outcomes are to be reviewed at Divisional Governance, with escalation for sustained non-compliance. Ongoing teaching of the learning disability pain tool and documentation standards occur during daily medical/surgical ward rounds with priority on using the learning disability pain tool to help in pain assessment/management in cases of learning difficulty, non-verbal and vulnerable patients. We will continue to reinforce the importance of Orthopaedic and Orthogeriatric documentation relating to pain management and checklist.

2. **David lost 3kgs in weight during the first month of his admission to EDGH. He was not eating nor drinking. There seemed to be little nutritional support available to David in the early stages of his admission causing him to lose almost 30kgs in total.**

On review of the medical records, there is documentation indicating in November 2023 Mr Dugdale was 60.3kg, on 17th February 2024, whilst on Cuckmere Ward he was 50.8kg and the last known recorded weight was taken on 25th April 2024 on Benson and Egerton Trauma Unit (BETU) as 42kg. We acknowledge this remains a significant weight loss during his admission and in light of this we have put the following provisions in place.

Completing the Malnutrition Universal Screening Tool (MUST), a tool used to identify adults who are malnourished or at risk of malnutrition, is now required on admission and weekly as a minimum. These should be monitored by ward Matrons and Heads of Nursing using the LiveFlo system, if a MUST score is 2 or above or there is documented poor oral intake for more than 48 hours this will trigger an automatic referral to Dietetics. In addition, nutritional plans must be clearly referenced within daily nursing documentation and where patients repeatedly refuse nutrition or hydration, this will trigger a multidisciplinary review (MDT) involving Dietetics and the Learning Disability Nurse, ensuring that barriers to intake are explored and addressed promptly. These measures are designed to ensure that nutritional concerns are escalated early and managed proactively.

To ensure improvements are maintained and monitored over time, quarterly audits will review MUST compliance, referral timelines, and weight-monitoring practices. LiveFlo monitoring by Matrons and Heads of Nursing will continue to support real-time oversight, and audit results will be reported through the IGM. Immediate reinforcement of these expectations has already taken place, audit results from 2025 are already available and outlined below but we will continue an audit cycle within three to six months.

As above, a 2025 audit has already taken place (attachment B) which demonstrated the following; the overall number of patients with a MUST score calculated on admission has increased to 65% compared to 55% last year, the number of patients with MUST scores

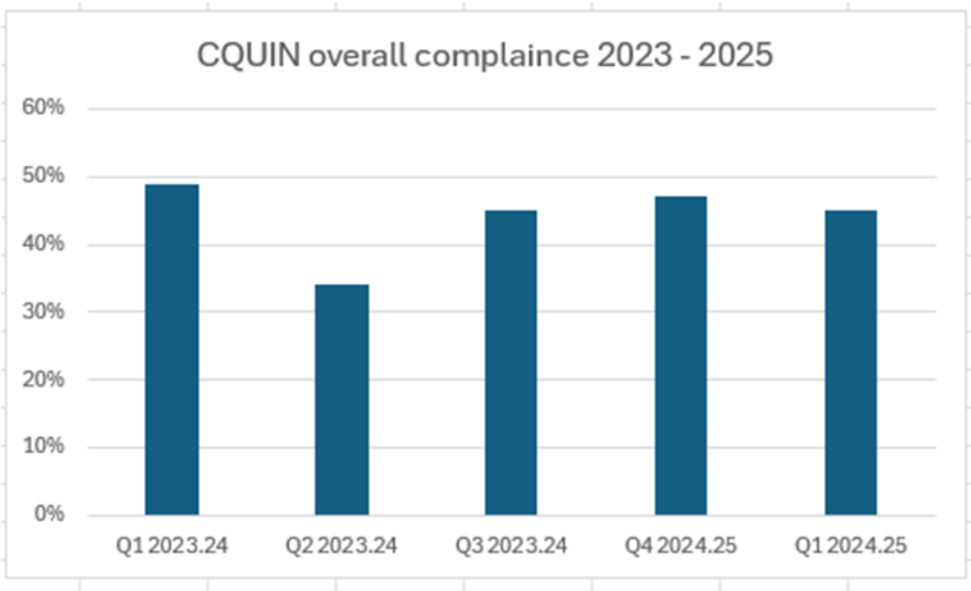
completed weekly has increased marginally (50% compared to 47% last year) and the proportion of MUST scores completed accurately has increased to 77% from 69%.

However, the rates for following the action plan have decreased. The first line provision of nutrition support was instigated in 31% of cases compared to 45% in 2024, and the proportion of individuals who were referred to the Dietitian of those who should have been had dropped to 37% from 61%. For Benson and Egerton Trauma Unit, the proportion of patients with at least 1 MUST score completed was good at 82%; however, the proportion of patients with MUST scores completed every week was one of the lowest in the Trust at 16%.

Following these results, a pilot project has recently commenced on BETU to look at improving nutritional standards on this ward. This involves additional Dietetic staffing to improve training, review of the equipment available for measuring nutritional status and trialling strategies to improve provision of high-quality nutrition on the ward. Learning from this project will be rolled out to the wider Trust.

3. **The pressure sore deteriorated to grade 4 during his admission which was a direct cause of his death. He was often found lying in soiled dressings with his pressure sore exposed and in pain by his visiting carers.**

Having previously participated in the national Commissioning for Quality and Innovation (CQUIN) programme including CQUIN12 Prevention and Management of Pressure Ulcers, that seeks to achieve 70-85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks, it was recognised that we had not met the expected compliance rate with initial audits. These were undertaken quarterly by the Lead Tissue Viability Nurse on a randomised selection of 100 patients and showed overall compliance was low (<50%).



As such there have been several actions that have since been undertaken since April 2024 to achieve and maintain long term effectiveness with our improvements. These have been led by the Pressure Ulcer Steering Group (PUSG) and the Tissue Viability Specialist Nurses. We have identified areas for improvement including maternity, elective care, and gateway areas. A new electronic audit tool was designed and implemented in August 2025 after a pilot, whereby audits are now undertaken monthly by each ward auditing a minimum of 20 patients.

The table below demonstrates that the target compliance of 70-85% has been achieved each month since August 2025.The latest compliance with all 4 criteria being met was 82% in January 2026, of the 545 patients audited.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Number audited	60	331	426	400	510	514	545
PURPOSE T2 assessment completed within 6 hours of admission in this clinical area or ward	60	300	394	365	462	444	447
If PURPOSE T2 assessed as orange / red; skin assessment and repositioning chart was completed within 24 hours	50	317	399	385	503	502	524
If PURPOSE T2 assessed as orange / red; there is documented evidence in the IPD of actions taken in line with the care plan generated in Nervecentre	50	323	398	377	500	503	509
For patients with a LOS over 7 days; there is evidence of PURPOSE T2 re-assessment every 7 days or when condition has changed	56	328	417	397	507	502	533
Overall compliance - Number responded 'Yes' or 'N/A' to all of the 4 PU CQUIN Criteria questions above	25	290	357	342	441	446	460

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Percentage compliance							
PURPOSE T2 assessment completed within 6 hours of admission in this clinical area or ward	100.0%	90.6%	92.5%	91.3%	90.6%	86.4%	82.0%
If PURPOSE T2 assessed as orange / red; skin assessment and repositioning chart was completed within 24 hours	83.3%	95.8%	93.7%	96.3%	98.6%	97.7%	96.1%
If PURPOSE T2 assessed as orange / red; there is documented evidence in the IPD of actions taken in line with the care plan generated in Nervecentre	83.3%	97.6%	93.4%	94.3%	98.0%	97.9%	93.4%
For patients with a LOS over 7 days; there is evidence of PURPOSE T2 re-assessment every 7 days or when condition has changed	93.3%	99.1%	97.9%	99.3%	99.4%	97.7%	97.8%
Overall compliance - Number responded 'Yes' or 'N/A' to all of the 4 PU CQUIN Criteria questions above	**41.7%**	**87.6%**	**83.8%**	**85.5%**	**86.5%**	**86.4%**	**82.0%**

To improve the standard of information and communication with patients and their carers, during ‘Stop the Pressure’ week in November 2025 the Trust launched new patient information leaflets ‘how to prevent a pressure sore’ (attachment C). The leaflet was adapted from a national document designed by patients for patients in collaboration with the then National Wound Care Strategy (NWCS). The leaflet is provided to all patients assessed as at risk of pressure damage or that have pressure damage. It provides clear information for staff to discuss with patients and includes an area for documentation of individual patient choices or specific advice given. It remains with the patient during the hospital stay and, in the home, and can also be used for sharing treatment plans with carers and relatives.

We also worked in partnership with NHS Sussex and other health care providers in Sussex to agree a mandatory framework for education and training related to wound care for clinical staff including pressure ulcers in line with the National Wound Care Strategy Programme (NWCSP). This includes eLearning and face to face taught elements and different tiers or levels of training are required for staff in different roles (attachment D). The Tissue Viability Nurses also provide face to face training as part of the mandatory induction and preceptorship training for newly qualified or new to Trust nurses. In addition to the mandatory training, the Trust has also introduced essential training days for clinical staff which provides training in human factors and simulated scenarios related to patient safety, for a blended and interactive approach to learning. This includes pressure ulcer prevention and management. This programme was developed by the Trust Deputy Chief Nurse with the Education and Training Team.

As part of the QI project commissioned by the Pressure Ulcer Steering Group (PUSG) on Benson and Egerton Traum Unit (BETU), additional bitesize face to face training has been piloted on the ward and on bespoke study days. The feedback and evaluation have been positive and reported back to the PUSG with a strong preference for face-to-face learning compared to mandatory eLearning. In turn PUSG requested the NHS Sussex Wound Care Group undertake an evaluation of the mandatory training framework, however the group disbanded in early 2026. As a result, the PUSG is planning to undertake a formal evaluation

of the Trust during 2026-27. Any proposed recommendations and changes to Trust mandatory and essential training will require a proposal to be approved by the Trust Education Oversight Group.

The Tissue Viability Nurses regularly provide targeted face to face training in wards and departments where requested. These can be ad hoc in response to incidents or identified knowledge gaps by department leads or on pre-planned routine ward study days with several topics covered, similar to BETU ward. Wards such as Cuckmere ward have received face to face training sessions, with some receiving ongoing 1-hour sessions monthly and pressure ulcer training every 2 months. BETU ward have introduced PFD focussed study days in 2025/26 which include 2-hour face to face pressure ulcers sessions. The training being provided also incorporates the Pressure Ulcer Prevention Policy update, dated 15/10/2025 (attachment E), the review of Nervecentre pressure ulcer documentation and the importance of medical photography in supporting pressure ulcer management and surveillance. Quarterly newsletters for learning related to wound care and pressure ulcers are also regularly circulated, and OSKA pressure ulcer webinar events are regularly shared via email by the Matrons as they arise.

Alongside the above, the PUSG plans several educational and promotional events for staff and patients during national 'Stop the Pressure Week' in November. The events rotate between hospital sites and community locations to encourage a range of attendees from all settings. The programme of events for these days is planned and coordinated by the tissue viability team and are designed to meet the most recent priorities or areas for improvement identified by learning from incidents and Inquests (attachments F&G). A programme of work/activity is developed annually by the trust Pressure Ulcer Steering Group (PUSG) to reduce risk of pressure damage based on learning from previous incidents, Inquests, audit findings and national guidance and recommendations. The PUSG meets bi-monthly and updates progress against these plans and reports to the Trust Information Governance Meeting and Quality and Safety Committee. The programme of work over the last 2 years has included learning and actions from the Inquest and the Prevention of Future Death Report (attachments H&I).

It is important to the Trust that we continue to make substantial and meaningful changes as this is an ongoing Trust-wide project that has significant impact on patient care, we intend to continue monitoring hospital acquired pressure ulcers by category, monthly auditing and monitoring of compliance with CQUIN12 PU Prevention and Management in line with NICE Guidance, this has been piloted and added to the EIC audits which showed overall compliance in January 2026 was 84.4%, and continued oversight through the Pressure Ulcer Group and IGM.

4. **In spite of receiving a statement from ESHT regarding improvements in nursing care my concerns were not allayed.**

The Trust recognises that previous actions focused primarily on awareness and training and did not sufficiently demonstrate sustained control of risk. The Trust is focusing on strengthening systems, escalation pathways, executive oversight and measurable assurance, consistent with national expectations for patient safety to reduce the risk of similar harm in the future.

The Trust acknowledges the risk associated with failing to respond to repeated concerns raised by carers, and several actions have been implemented to strengthen listening, communication, and escalation culture. On the day of admission, or as close to this as possible, ward staff now jointly plan care with carers and family members to establish an agreed baseline and clarify how changes in the patient's condition, such as how they express pain, should be communicated. All concerns raised by carers regarding pain,

deterioration, or unmet needs must be documented and acted upon. Alongside this, a Trust wide project and a Sussex wide working group are focusing on improving communication, support, and integration of carers, recognising that while system wide change will take time, these programmes will drive incremental improvements.

A theatre-specific project is also underway to enhance communication with patients with learning disabilities and their carers. The Trust acknowledges that patient passports are inconsistently updated and used, and a Trust wide initiative, supported by the Transformation Team, will raise awareness and improve staff understanding of how to use passports effectively. Where concerns persist or remain unresolved, staff are required to escalate via Martha's Rule if carers or family have not already done so. Since September 2025, intensive work has been undertaken to raise the profile of Martha's Rule through Trust communications, posters, and the appointment of a dedicated nurse to lead its implementation. Communication with patients with learning disabilities and those with cognitive impairment has also been proposed as a 'Quality Account' initiative for 2026/2027 to ensure sustained organisational focus. Any failure to escalate concerns appropriately will be reviewed as a patient safety incident. Assurance will be provided through ongoing review of Martha's Rule activations and outcomes, with themes monitored at IGM. Implementation of the above will be immediate with continuous monitoring.

Regarding patients who lack capacity and have no family advocate available, an early referral to an Independent Mental Capacity Advocate (IMCA) is now required for all high-risk decisions. This ensures that patients receive the necessary support at the earliest opportunity. Hospital Care Plans must be uploaded to Nervecentre and actively referenced within daily care documentation so that staff have immediate access to up-to-date information on the patient's needs, risks, and agreed approaches to care. Learning Disability MDT oversight is expected for all complex or prolonged admissions. While this should already occur, with MDTs inviting the Learning Disability Nurse into discussions early in the patient's journey, this does not always happen consistently. There will therefore be a renewed focus on raising awareness across all clinical teams to ensure that the Learning Disability Nurse is involved promptly and appropriately.

The Trust currently employs a single Learning Disability Nurse whose role is to act as a subject matter expert, advisor, and lead for complex cases. A business case is being developed to explore additional support, with the aim of appointing one additional Learning Disability Nurse per ESHT site to improve coverage and responsiveness. Additionally, as a potential alternative, the Learning Disability Nurse is exploring with local support groups and the Trust's volunteer services to consider how volunteers may help maintain more regular contact with patients with learning disabilities and their carers and feeding back relevant information to the Learning Disability Lead. Audits will review the timeliness of IMCA referrals with the first audit scheduled within six months and the Learning Disability Nurse will continue to report into Safeguarding and Quality forums to ensure appropriate oversight and organisational learning.

I hope this letter provides you and those who knew and cared for Mr Dugdale with assurance that we have taken the learning extremely seriously and have made significant improvements. Once again, my sincere condolences to Mr Dugdale's family and friends.

Yours sincerely,

Chief Executive Officer