

**HM Coroner Sarah Clarke**  
North East Kent Coroners  
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Oakwood Road  
Maidstone  
Kent  
ME16 8AE

Chief Executives Office  
Trust Offices  
Kent & Canterbury Hospital  
Ethelbert Road  
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Kent  
CT1 3NG

6<sup>th</sup> March 2026

Dear Ma'am

**Regulation 28- Prevention of Future Deaths (PFD) response on behalf of East Kent Hospitals University NHS Foundation Trust regarding the death of Mrs Sarah Heaver.**

This is a formal response to the PFD issued to East Kent Hospitals University NHS Foundation Trust (the "Trust"). At the conclusion of the inquest on 23<sup>rd</sup> July 2025, the coroner afforded the opportunity for the Trust to respond to her concerns before issuing a PFD (a copy of this response is attached for ease). This response was sent on the 3<sup>rd</sup> August 2025.

The coroner's concerns within the PFD are the same as the concerns from the conclusion of the inquest. The Trust has made improvements and changes since the letter from August 2025, which we hope reassures you that we are always learning and trying to improve patient care.

1. **Coroner's concern: She had a GCS of 3 with unknown down time and an unclear history. No CT was undertaken despite being indicated. I am concerned that appropriate neurological investigation was not carried out.**

In his evidence at the inquest and in the August 2025 letter, [REDACTED] referenced the following guidelines:

1. NICE CG176 (Head Injury guidelines)
2. Royal College of Emergency Medicine guidelines on self-harm
3. 2022 NICE guidance (NG225) guidance on self-harm.

[REDACTED] in preparation for this response has confirmed that his stance would remain the same. The evidence and handover from the paramedics on arrival was clear on the history of Mrs Heaver. Whilst the timing of the overdose was unclear, she had no signs of trauma i.e. a head injury which would have necessitated a CT. It was evident that she had taken an overdose and the medication blister packs were found next to her.

After convening her to hospital and administering a bolus of Naloxone in the ambulance, her GCS improved significantly to 8 (from 3) by the time she was handed over to the resus team at A&E, her GCS further improved very rapidly to 13.

Mrs Heaver's presentation is sadly not uncommon in A&E and there are clear guidelines on when a CT is mandated when a patient presents after self-harm. For self-harm involving head injury or potential loss of consciousness, standard urgent care protocols for head injury assessment should be followed, which is outlined in the NICE Head injury guidelines NG232 (section 1.5, page 17,18).

In NG232, self-harm is mentioned as an indication for CT Head, if the patient has a dangerous mechanism of injury or if the clinician is unable to obtain a reliable history due to the patient being intoxicated.

#### **Red flag signs for urgent CT Head in Head injury:**

1. GCS <13
2. On anticoagulation
3. Trauma signs (panda eyes, battle's sign, CSF leak from nose / ear, suspected skull fracture
4. Two or more episodes of vomiting
5. Neurological deficit (limb weakness, speech problems)

If Mrs Heaver had not responded to her Naloxone infusion, this could have indicated that there was something else happening clinically (i.e. a brain bleed) and a CT would have been carried out immediately upon arrival to A&E.

Mrs Heaver recovered clinically from this attendance and there was nothing exhibited during that attendance that warranted a CT scan being undertaken. There was nothing to suggest that her mental health related to a tumour and indeed this was an incidental finding on post-mortem. The A&E staff are very aware of the signs of a pituitary tumour, and aside from depression which she had suffered for some time, she showed no other symptoms of a tumour.

As an aside, this case was discussed in the Trust's Mortality meeting and the general consensus was that management was appropriate in accordance with NICE guidance. The inquest did highlight issues with documentation, it was not of an optimal standard and not in line with GMC Good Medical Practice guidance. We have presented this to the Junior Doctors on their trust induction as well to ensure that notes are accurately recorded and not 'copy and pasted'.

2. **Concerns that no structured neurological observations were undertaken on a patient presenting with such a low GCS, risking deterioration being missed.**

The Trust's letter in August 2025 showed how Mrs Heaver's GCS improved rapidly during transport (after the bolus of Naloxone) and then upon admission to hospital. However, review of the notes identified the need for improved documentation of neurological observations. The case identified the need for standardised and frequent GCS documentation. The Trust's Deteriorating Patient Lead Nurse has reviewed the notes and implemented improvements to the Trust's electronic documentation system.

#### **Digital improvements**

The Sunrise digital system currently used within the Trust records patient documentation and clinical observations via electronic flowsheets. At present, neurological assessment within the observation flowsheet requires clinicians to record alertness using the ACVPU scale in alignment with National Early Warning Score 2 (NEWS2). Where an abnormal alertness

parameter is entered (i.e. any response other than “Alert”), the system prompts the user to indicate whether a Glasgow Coma Scale (GCS) assessment is required. However, even when a clinician confirms that a GCS assessment is clinically indicated, completion of the GCS remains non-mandatory, and observations may be submitted without this assessment being recorded. Furthermore, the current configuration requires the clinician to manually locate and complete the GCS assessment further down within the flowsheet, which introduces risk of omission during time-critical situations.

In response to these identified risks, the Deteriorating Patient Lead Nurse has co-designed a revised digital deteriorating patient pathway as part of a wider system enhancement. Under the proposed changes, where a clinician indicates that a GCS assessment is required, the assessment will automatically become visible and directly accessible within the observation workflow. In addition, completion of the GCS will be mandated before submission of observations where reduced consciousness is documented and GCS completion has been selected. These changes are intended to reduce the potential for human error, ensure compliance with neurological assessment standards, and enhance patient safety during episodes of clinical deterioration.

Separately, the Sunrise system is scheduled to upgrade from Version 21.1 to Version 25 (V25) by Summer 2026. The digital deteriorating patient pathway, including the revised neurological observation functionality, is due to be completed and submitted for system testing during Quarter One (April–June) 2026. Subject to successful testing and governance approval, implementation of the updated pathway may occur prior to the full V25 system upgrade, with formal go-live dates to be confirmed following completion of testing.

### Policy updates

In addition, as mentioned in the Trust’s letter in August 2025, the Vital Signs Policy has been reviewed and updated effective from November 2025. This revision incorporates specific learning identified from the incident involving Mrs Heaver and reflects the Trust’s commitment to continuous improvement, education, and the embedding of best practice into clinical governance frameworks.

The following amendments have been incorporated into the Policy:

#### **Section 9.3**

The medical team must be informed of any change in a patient’s neurological condition, specifically a deterioration of two points in the Glasgow Coma Scale (GCS). A patient with a GCS of 9 or less may require intubation to protect their airway and to support effective ventilation. Consideration must be given to referral to Critical Care Outreach and/or the Critical Care Team.

#### **Section 9.7**

Patients receiving Naloxone infusions are required to undergo observations, including neurological assessment, every fifteen minutes for the first hour following commencement of the infusion and thereafter every thirty minutes until a medical decision has been made to discontinue the infusion, in accordance with guidance issued by the Royal College of Emergency Medicine (2024).

While this level of escalation did occur in Mrs Heaver’s case, where a naloxone infusion was recommended following review by Critical Care Outreach team, the Trust has now formally embedded this requirement within local policy. This ensures that learning from the incident is translated into explicit standards of practice, thereby strengthening consistency, accountability, and patient safety across all clinical areas.

Furthermore, the inclusion of guidance from the Royal College of Emergency Medicine (2024) within the revised policy reinforces alignment with national evidence-based standards and supports the delivery of best practice in the management of Naloxone infusions. This reflects the Trust's commitment to maintaining gold-standard care in accordance with nationally recognised clinical guidance.

Importantly, this policy update is not solely procedural amendments but are actively embedded within the Trust's education and training infrastructure. The revised standards now inform and support the following programmes:

- **ALERT Course**  
A nationally recognised course utilising a structured and prioritised approach to patient assessment and management. It promotes early recognition of clinical deterioration, proactive intervention, and effective management of acute illness.
  - **Resuscitation Training – Immediate Life Support (ILS)**  
The Trust's Immediate Life Support course is accredited by the Resuscitation Council UK and is designed for healthcare professionals involved in the early recognition and management of acutely / critically ill patients. This includes practical, simulation-based training to reinforce the assessment and escalation of deteriorating patients, including those with reduced or fluctuating GCS.
  - **Governance Meetings**  
The revised policy will be formally presented at Urgent, Emergency, and Acute Medicine governance meetings by the Consultant team. This ensures that clinical expectations and gold-standard practice in the assessment, escalation, and management of patients with reduced or fluctuating GCS are clearly communicated and understood across relevant specialties.
3. **Throughout this investigation I was presented with inconsistent, unreliable and incomplete medical records. This significantly hindered my ability to investigate the death and creates a risk of future patient harm.**

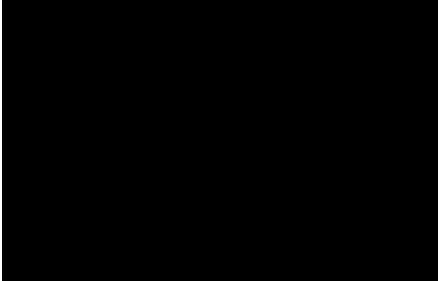
The coroner will be aware that the legal services department in the Trust was under immense pressure last year when this inquest was opened and concluded. There was high staff turnover and the department was not running effectively. A review of the file notes that numerous requests were made by the coroner's officers for the medical records and imaging but this was unfortunately not sent in a timely manner. This caused the inquest to be adjourned and caused distress to the family. The Trust apologises for this. The team is evolving and undergoing a period of transformation to ensure that communication happens promptly. We have put in stringent Standard Operating Procedures (SOP's), Key Performance Indicators (KPI's) and introduced case handlers for each inquest to ensure that, from the offset, key information is provided to the coroner and the officers. We have been praised on the improvements that have taken place since July 2025 and we will continue to ensure we are efficient with our communication.

4. **I am concerned that the patients are discharged from acute hospital settings on the understanding that they will receive psychiatric input equivalent to hospital admission, only for it to later become apparent that there is no access to a psychiatrist or prescriber for several days, particularly over band holidays.**

We believe that this was an issue that arose at the inquest itself and KPMT will respond to this in full.

We hope that the changes and learning that has taken place reassure the corner that we have taken steps to mitigate this sad case repeating itself and the Trust will continue to highlight this case in learning situations.

Yours sincerely



**Acting Chief Executive**