Mid and South Essex NHS Foundation Trust

Basildon Hospital
Nethermayne
Basildon
Essex
SS16 5NL

28 April 2026

FAO Ms Jyoti Gill
His Majesty's Assistant Coroner
SEAX Court
Chelmsford
Essex

Dear Madam,

Inquest touching on the death of Miss Viviana-Ray Butnaru- Regulation 28 Report

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 4 March 2026 in respect of the above. The report was issued to Mid and South Essex NHS Foundation Trust (MSEFT) and The Royal College of Paediatrics and Child Health following the Inquest hearing which concluded on 4 February 2026.

The 'local concerns' attributed to MSEFT as noted within the Regulation 28 Report have been carefully reviewed by senior clinical colleagues, I hope that this response addresses your concerns and provides both yourself and Viviana-Ray's family the necessary assurance that we have taken robust action to learn from Viviana-Ray's sad death.

Local Concerns:

(3) Chest X rays which showed cardiomegaly were not reported officially by a radiologist until several days later.

Response: The Director of Nursing for the Clinical Division of Clinical & Support Services has undertaken a review of Viviana-Ray's imaging timeline. As you are aware Viviana-Ray had a chest x-ray examination undertaken on 24 October 2024 at 23:56 hours, whilst she was in Basildon Emergency Department (ED). Plain film examination images are initially clinically reviewed and interpreted by a member of the ED team to guide onward care for patients, and in addition they are formally reported on by the Radiology Department. The chest x-ray from 24 October 2024 was formally reported by a Paediatric Radiologist on 29 October 2024 at 15:09 hours. This reporting timeframe totalled 111.5 hours. Similarly, the chest x-ray examination Vivana-Ray had on 25 October 2024 at 20:14 hours was formally reported by a Paediatric Radiologist on 29 October 2024 at 15:39 hours. This reporting timeframe totalled 86.5 hours.

I enclose a copy of the Trust's Radiology Report Turnaround, Escalation and Risk Stratification of Backlog Policy (MSEPO-24003), which advises the maximum time from exam to report for ED plain film x-rays, is 72 hours. The Trust recognises the turnaround reporting timeframes detailed for Viviana-Ray's x-rays deviate from our policy and non-compliance with this Key Performance Indicator (KPI) has been recognised and is under review and management via the Trust's risk register, under reference: 1086.

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At the time of Viviana-Ray's admission, the Trust had a process in place whereby the Paediatric Team could escalate a clinical concern to the designated Duty Radiologist from 09:00 hours to 20:30, 7 days a week. The escalation is a specific request to expedite an imaging report. Regrettably, this was not done in Viviana-Ray's case, and our conclusion is that the process was not well known by staff at that time.

The Radiology Department identified that guidance for clinical teams on how to expedite an imaging report due to clinical concern was not documented in Trust radiology policies and procedures. As such, the Director of Nursing has confirmed that a review of the Trust's policy, Guide for making the best use of a Radiology Department (MSEGL23134) will be completed by 1 June 2026 to ensure an updated version is formalised to include this guidance going forward. The Trust will be able to share a copy of this updated policy with you in due course if it is of assistance.

As a result of these guideline changes, targeted sharing of the changes will be undertaken with the Paediatric teams across our sites within MSEFT, alongside the updated guideline being available on the Trust's intranet page, which is accessible for all staff.

(4) Underlying causes for metabolic acidosis were not fully explored. Greater awareness of the difference between metabolic and respiratory acidosis is required.

Response: Both the Clinical Lead for Paediatrics and the Associate Director of Nursing for Paediatrics have confirmed the service identified these issues during the initial review of the incident, and a specific action was implemented to address concerns relating to blood gas interpretation and documentation, particularly where results were inconsistent with the working diagnosis.

Targeted bite-size education sessions focusing on recognising abnormal blood gas results and appropriate escalation were delivered by the Clinical Practice Facilitator (CPF) team across Children's Emergency Department and inpatient wards. To further support staff in real-time clinical practice, business-card sized blood gas prompts were distributed following the sessions and staff attached these to their lanyards. These prompts are intended to support early recognition of deteriorating trends and prompt timely escalation.

Viviana-Ray's case has been discussed at various trust forums, to share learning and the associated actions that have been taken. The case was presented at Basildon's site Mortality and Morbidity (M&M) meeting in March 2026, which is attended by consultants, tier 1 and 2 doctors and clinical nurse facilitators. Her case has also been discussed at the cross-site Grand Round in January 2026, during this meeting the case was discussed with learnings and differential for metabolic acidosis including cardiac and attended by consultants, tier 1 and 2 doctors and Associate Directors of Nursing. A safety bulletin has also been circulated to all staff in February 2026.

Further learning has been reinforced through local teaching sessions, supported by multiple delivery methods including verbal teaching, live simulation, and a formal "learning from incidents" bulletin. This multi-modal approach has ensured learning has reached both nursing and medical teams across a range of forums.

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(5) Incomplete documentation to be addressed to include all updates from nursing staff in relation to observations and escalations; and handovers from the medical team to one another to be clearly recorded.

The paediatric service recognises that there were gaps in fully documenting nursing observations and escalation actions. In response, Children's Early Warning Tool (CEWT) refresher training has been delivered to all relevant nursing and support staff, with specific emphasis on clear documentation of escalations made and responses received.

CEWT audits on the inpatient wards were initially undertaken on a monthly basis. Due to increasing variability in compliance, audit frequency was escalated to daily audits from September 2025, enabling earlier identification of non-compliance, more timely feedback to clinical teams, and improved real-time assurance of escalation practice.

In Children's ED, daily CEWT audits have been in place since March 2025, providing continuous oversight. Between October 2025 and March 2026, CEWT compliance remained 90 - 100% in Children's ED, and 85 - 95% on the inpatient wards.

Where audits identified variability or reduced compliance, targeted improvement actions were implemented. These included allocation of a named CEWT champion on each shift, senior nurse spot checks, shared learning discussed during safety huddles and real-time feedback provided directly to staff. It is recognised that during periods of high patient volume and acuity, compliance may temporarily dip due to increased clinical pressure. During these periods, mitigations are implemented, including the use of support workers to assist with observations, to maintain safety and oversight.

In parallel, the Trust is implementing the National Paediatric Early Warning System (nPEWS) across paediatric services. Robust governance arrangements are in place, including a weekly task-and-finish group to oversee delivery and provide assurance. A comprehensive 12-week education and training programme started on 13 April 2026 for the planned June 2026 go-live, ensuring staff are prepared and supported.

nPEWS explicitly incorporates clinical intuition and carer concern into escalation criteria, reinforcing professional judgement alongside physiological observations. The revised charts also introduce a dedicated escalation record, strengthening visibility, accountability, and assurance around escalation and clinical decision-making.

In addition, monthly documentation audits continue across both Children's ED and the inpatient wards. Documentation compliance in Children's ED remained above 95% between October 2025 and March 2026. On the inpatient wards, compliance ranged between 75% and 95% during the same period. Reduced compliance identified in December 2025 related to illegible handwriting, unsigned amendments, and incomplete nursing documentation. Feedback was provided directly to staff, with reminders regarding documentation standards and their importance for patient safety and medico-legal assurance. Subsequent audits have demonstrated improved compliance, indicating that learning has been embedded.

Finally, the nursing teams have reflected deeply on Viviana-Ray's death, and those directly involved have completed written reflective accounts alongside one-to-one refresher

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sessions covering the areas identified above. Learning from this case has also been extended to the wider nursing and multidisciplinary team.

Meaningful improvements have been made to our practice across all services involved, and the Trust remains fully committed to ongoing learning, reflection, and careful monitoring following this very tragic case.

We understand that the Court will share a copy of this reply with Viviana-Ray's family.

If I can assist you further in this case, please do not hesitate to contact me.

Yours sincerely

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Chief Medical Officer
Mid and South Essex NHS Foundation Trust

Enclosed:

i) MSEPO-24003 Radiology Report Turnaround, Escalation and Risk Stratification of Backlog Policy

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