Nottinghamshire Healthcare
NHS Foundation Trust

Chief Executive's Office
The Resource
Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA

[redacted]

Date: 15 March 2022

Private and Confidential

Dr Didcock
HM Assistant Coroner for Nottingham and Nottinghamshire
Nottinghamshire Coroner's Office
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Dr Didcock,

Please find below the organisational response to the recently received Preventing Future Deaths Report, following the unfortunate death of Mrs. Whitehead.

The Matters of concern raised within the report:

Unclear dose/type of sedation medication given, possible excess dose given, poor documentation.

A medication error did occur during Mrs. Whitehead's care. This involved the incorrect dose of administered Oral Diazepam being communicated to the Ward Manager and Duty Doctor. With this incorrect information they agreed to administer Rapid Tranquilisation in the form of an Intramuscular injection of Lorazepam.

When writing the above dose in the patient's medication card, the Ward Manager recognised the error, and contacted the Duty Doctor again to assess the likely impact.

The assessment was that the dosages given were within British National Formulae guidelines, and as such would not negatively impact on Mrs. Whitehead's physical health. This assessment has been considered by senior medical colleagues within the Trust, who are in agreement with the conclusion of this assessment.

Mrs. Whitehead was observed constantly following this, with a member of staff within an arm's length of her at all times.

The staff involved in the medication error engaged in supervision with their manager following the incident and completed self-reflection pieces since this time. They are very aware of the error and its potential implications.

Delayed recognition of Mrs. Whitehead's declining condition

Mrs. Whitehead was administered Rapid Tranquilisation with the aim of reducing her acute presentation. Her physical observations were taken every 15 minutes after this, scored using the

National Early Warning Scale (NEWS2) and over the following hour remained stable. This was reported to the Duty Doctor who confirmed that the physical observation checks were no longer required and normal mental health focused observation should take over.

The investigators were unable however, to see an assessment of consciousness levels within the above and have hypothesized that, whilst Mrs. Whitehead presented as confused during this time, this may have increased after the medication and her NEWS2 score may have increased indicating that more prolonged physical observations were required.

As a response the Directorate has re-printed new refreshed supplies of the credit card sized NEWS2 quick reference guides (Appendix 1), which identify the physical health parameters and trigger points for escalation to local medical colleagues or the emergency ambulance service. The card is to be worn on a lanyard alongside individual identification badges, acting as an immediate reminder. These have now been confirmed as having been redistributed across our inpatient sites within Adult Mental Health Services and have been shared with the other directorates to ensure consistency across sites.

Additionally, the Division is rolling out handheld devices that allow staff to immediately enter physical observations into the NEWS2 electronic system (and patient record). This will automatically calculate the NEWS2 scores and alert if interventions or emergency care is required. Confirmation has been received that these have been made available and are in use on all Adult Mental Health inpatient areas.

Two senior staff members have been identified to work with individuals and groups from the Lucy Wade Unit to ensure they fully understand how to undertake comprehensive NEWS2 assessments. The key focus of the sessions is about confidence-building, particularly regarding decision-making at the time of an urgent clinical incident. They will additionally ensure that all staff are supported to recognise signs of an Anaphylaxis reaction and its associated emergency treatment with Adrenaline. This will include individual and group training and the completion of medical emergency scenarios to test knowledge and processes in a more realistic, true-life environment. We are initially prioritising the wards in the north of the county and intend to have this area fully compliant with the training target in this area by mid-April 2022. Additionally, the intention is then for 80 percent completion target in line with the Trust training compliance matrix for all Adult Mental Health inpatient nurses to have completed the formal training and engaged in the scenario-based training by end of May 2022. At this time, 34 staff (approximately one third of the required staff group in the north of the county) have completed the scenario-based training and 59% of AMH inpatient nurses have completed the enhanced NEWS2 training. A copy of the scenario-based aspect of this training package is attached as Appendix 2.

A letter dated 27 January 2022 describing the learning from this event has been written and was distributed throughout the Directorate's in-patient services via formal letter and email copies the week followings its completion. A copy is enclosed with this letter titled Appendix 3.

All direct care in-patient staff in the Trust complete Hospital Life Support training every eighteen months, which includes the completion of NEWS2 assessments and associated escalations; plus, recognition of Anaphylaxis and its emergency treatment using Adrenaline. Currently Adult Mental Health services are at 84 percent compliance, which is within target for the directorate. The lesson plan for this core training is being reviewed to confirm that sufficient time is spent on all aspects of

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the above, ensuring that staff are appropriately trained and have completed a competency assessment to confirm this. A further update in relation to this will be available by the end of May 2022.

The Trust Resuscitation committee is convening (initially on 9 March 2022) to review the Rapid Tranquilisation Policy and will explore, review and determine what actions should be taken should a patient fall asleep post rapid tranquilisation administration. At the initial meeting it has been agreed that an external intensivist will be consulted to advise as part of this process. A clear understanding of how staff will make the assessment to determine if the patient is sleeping or if the patient is unconscious will be confirmed and any additional learning and development planned.

Currently the Directorate are placing patients on constant observations until they are mobile and using a Pulse Oximeter to continuously monitor blood oxygen saturation and pulse rates. This has been communicated to staff members via the aforementioned letter and within ward team meetings and both group and individual supervision sessions.

No medical clerking from admission until her collapse

On the night of admission, 3 May 2021, Mrs. Whitehead was seen by the duty doctor Dr [redacted] who clerked her in and made an entry at 23:11. She also completed the core assessment on RIO at that time. On her approach, however, Mrs Whitehead was visibly afraid despite attempts by patients and staff to console her. She did not respond verbally to Dr [redacted] attempts to speak to her. She was backing away and visibly frightened. Dr [redacted] understood from nursing staff that Mrs Whitehead's behaviour had been the same since her arrival on the ward and she had not spoken to any staff thus far. Dr [redacted] attempted to complete a full clerking but because of Mrs. Whitehead's mental state and clinical presentation, by necessity, much of this information was taken from RIO and also the GP information from the portal, other than the objective observations she could make. She was unable to complete a physical examination, an ECG or bloods because Mrs. Whitehead was too frightened and disturbed. She recorded her reasons in RIO progress notes and she recorded a plan to hand over to the day team to request a re-attempt at completing the missing aspects of the clerking. This is in keeping with the Trust's policy on Physical Assessment and Examination of patients (Appendix 4), which states that a physical examination should take place within the first 24 hours but recognises that sometimes examination is not possible, such as occasions when the patient refuses or is too disturbed, and the situation should be reviewed at appropriate intervals. The Policy also recommends reattempting within the first 48 hours and at regular intervals thereafter.

Dr [redacted] emailed the ward doctors for the following day, Dr [redacted] and Dr [redacted] This email was received and acknowledged by Dr [redacted] who stated she would see the patient the following day.

The handover has been reviewed by the Associate Medical Director and by the Director of Medical Education, and they have considered that passing this work to the ward doctor rather than the next day duty doctor was appropriate, given the presentation and physical needs would be ongoing for some days, and following through from the initial clerking sits appropriately with ward doctors. The detail of the handover on the morning of 4 May 2021, as Dr [redacted] finished her shift, has been clarified by the Associate Medical Director and did take place face to face as per advised practice.

The daytime duty doctor for 4 May 2021 was made aware of the patient by nursing staff as Mrs. Whitehead remained very unwell and they recognised that her prescribed PRN medication may have contained lactose. The duty doctor undertook some liaison with pharmacy colleagues about choice of medication given her allergies. There are no further entries in RIO progress notes about consideration of further attempts to complete a physical examination and baseline investigations, but there is a clear description in the notes of Mrs. Whitehead continuing to present as mentally very unwell and not engaging with staff.

When interviewed by the investigators Dr [redacted] stated that on Wednesday the 5 May 2021 she was not able to do a full examination as the patient was very agitated, therefore towards the end of her working time she handed the case over to the on-call doctor. She informed him that Mrs Whitehead was agitated, and he may be called to see her later in the shift.

She was examined physically by Dr [redacted] duty doctor, on the evening of 5 May 2021. This was after rapid tranquilisation had occurred. He records an entry in RIO at 17:45. He had been asked to see Mrs. Whitehead by ward nursing staff, with concerns about her mental state including agitation, verbal aggression and chaotic behaviour, along with physical symptoms of copious loose stools and nausea. He physically examined the patient including her conscious level, hydration status, most recent physical observations, chest examination, pulse, heart auscultation, capillary refill time, abdominal examination including auscultation for bowel sounds.

The Associate Medical Director for the Mental health Division and the Director of Medical Education have jointly emailed all junior and consultant medical staff in the division to remind them of the physical examination policy, the importance of re-attempting physical assessment at regular intervals if unable to complete it at the point of admission, and the importance of documenting the review of completing the physical assessment in the notes.

No Consultant involvement after admission

Lucy Wade ward is staffed by two consultants, Dr [redacted] Consultant Clinical Psychologist and Dr [redacted] Consultant Psychiatrist. Dr [redacted] is a fully qualified approved clinician under the Mental Health Act. This is a new role, known as a Non-Medical Approved Clinician or also known as Multi Professional Approved Clinician. In order for medical aspects of inpatient care to be fully provided Dr [redacted] has a programmed activity in his job plan to support Dr [redacted] they have a regular Tuesday meeting to discuss her patients, and he sees some of her patients directly if indicated. He provides senior medical input if needed during the rest of the week. He also supervises the clinical work and education of the junior medical staff on the ward. On the week in question Dr [redacted] was on annual leave, and his annual leave was covered by a colleague, Dr [redacted] Consultant Psychiatrist at The Millbrook Unit.

On admission Mrs Whitehead was assigned to be under the care of Dr [redacted] Dr [redacted] saw her in Ward Round on 5 May 2021, accompanied by a Clinical Psychologist, Dr [redacted] and a staff nurse. At this time Dr [redacted] was self-isolating due to testing positive for COVID 19 and was working remotely. She led the Ward Round on MS teams. The Trust position during the pandemic has been for clinicians to work remotely if they test positive and are well enough to work. Dr [redacted] was due to end her period of isolation the following day, 6 May 2021. There was a full MDT discussion, but Mrs Whitehead was unwell and unable to engage with Dr [redacted] via MS teams.

The outcome of the Ward Round in relation to consultant involvement was that Dr [redacted] would attempt to see her again the following day when she was out of isolation. Dr [redacted] also planned to consider transfer of consultant care to Dr [redacted] on his return to work because of continuity of care as he had worked with Mrs Whitehead in the community.

Dr [redacted] or Dr [redacted] could have accessed consultant psychiatrist support at this point in time from Dr [redacted] They did not do so as, at the time, they did not think this was necessary. Unfortunately, Mrs Whitehead had suffered the respiratory arrest and had been transferred before the face-to-face consultant review could take place.

Clinical Directors of the service plan the balance of workforce need and annual leave, with particular focus on high leave periods, such as school holidays, bank holidays and religious festivals. Annual Leave will not be agreed unless sufficient cover arrangements are in place, and this has been communicated throughout the workforce via conversations with lead consultants and email correspondence.

Dynamic management of unplanned absences are harder to resolve, however the medical workforce has committed to offer flexible cover arrangement in these circumstances, led by the local area lead consultant.

To offer Divisional resource oversight, a daily report of all Covid related absences during the Covid spikes is collated for the Associate Medical Director.

All cover arrangements are communicated to the ward and management teams, held on a central database that can be reviewed, and routes of escalation are known.

Inability to reach Duty Doctor for deteriorating patient

The Trust takes the difficulty experienced by the nursing team in making contact with the duty doctor for a deteriorating patient extremely seriously. The nursing team describe "ringing continually but the doctor did not answer the phone" from about 20:45 on 5 May 2021 and report inability to leave a message.

From investigation of this issue, it is known that the duty doctor had one registered missed call, which he noticed at 21:10 that had been made at 20:55 and no message had been left. He had been seeing another patient, and he had taken blood samples across to the laboratory at Kingsmill Hospital and noticed the missed call as he was walking back. We have explored this further and concluded that the most likely explanation is that he lost mobile signal. In response, this has been reviewed with the Trust Chief Digital Information Officer and the Head of ICT Operations. It has been recognised previously that a number of our sites lack a mobile phone signal, and the solution in place for some years is to ensure all junior doctor smart phones are enabled for Wi-Fi calling. It is highly probable that connection with Wi-Fi calling was lost when he went to the laboratory at Kingsmill Hospital, and he also had no mobile phone signal.

The recommendation from the SI report was to have a "crash bleep". This was considered but discounted as the duty doctor covers a number of geographical sites and cannot provide an immediate response. Therefore, the response to a medical emergency needs to remain as 999.

The option of a "back up bleep" to be an alternative contact method if the mobile phone fails was then considered. Advice from IT was that there is a national target to remove bleeps from the NHS, which was to be achieved by the end of 2021. Alternative options include various apps, but they all require a smartphone and a reliable signal or Wi-Fi calling. We have therefore reviewed all first on call rotas to establish all locations where the junior doctor may need to visit as part of their duties. For the duty doctor at Millbrook, in addition to Millbrook itself, this consists of all of Kingsmill Hospital Campus – including Kingsmill Hospital Pathology Lab, along with Alexander House, Bracken House and the road in between. ICT have now developed a solution using Wi-Fi calling via a specific NHIS wireless network. Staff will need to select this network when inside Kings Mill and there is a requirement for them to register using first name, last name and Trust email address. This is a one-off registration per mobile phone device allowing auto-connect to occur at each subsequent visit. Once connected to the wireless network, smartphones with Wi-Fi calling enabled should be able to initiate and receive calls when there is no cellular mobile phone signal. This solution is available with immediate effect and extends onto a non-Trust site. The Head of ICT Operations has communicated with medical education to ensure all junior doctors are informed and have the user guide (Appendix 5).

Additionally, Millbrook Mental Health Unit is co-located within the grounds of the Kings Mill Acute Hospital. As such, Trust leads have liaised with acute colleagues at Sherwood Forest Hospital Trust to assess whether this proximity is sufficient to allow the Acute Emergency Response "Crash" team to attend medical emergencies. This would offer the quickest and highest level of response to medical emergencies in the future. In February 2022 they agreed that this cover is possible. However, before fully operational we have to ensure appropriate additional equipment is in place and develop a list of practical issues to cover off, which is currently being managed by the Head of Nursing for the Physical Health Division and the Associate Medical Director for the Clinical Development Unit. Throughout March 2022 the operational challenges will be worked through with the aim to implement this process as soon as it is deemed safe to do so. In the interim period the primary action remains to call for an ambulance via 999. Further updates can be provided to the Coroner's office once we can give assurance that this system is fully operational.

Delay in calling paramedics

As detailed above, colleagues made attempts to contact the Duty Doctor when they recognised that a medical emergency was unfolding.

The primary message to staff, is that they must call for immediate support from the Ambulance service when they recognise that someone's physical health is rapidly deteriorating, and a medical emergency is or is likely to occur. This has been included clearly within the notification of learning letter already referred to within this response (Appendix 3).

Summoning a local medical response to support their life support interventions is a secondary action.

Additionally, senior leads, including the AMH General Manager has liaised with the East Midlands Ambulance Service to ensure they are aware of the nature of our Mental Health Units, the limitations of the life support interventions that can be made, and off site working of medical colleagues. Between them they have agreed that when an emergency response is requested, it

becomes a priority one call, initiating an immediate response. This remains the case until the emergency crash process with Sherwood Forest Hospital Trust is in place and safely operational.

Delay in Paramedics gaining access to the ward

Once the ambulance response was confirmed, staff focused on carrying out hospital life support interventions with the patient, as well as caring for the wider patient group.

No one was allocated to go to the main reception to greet and hurriedly escort the ambulance team through to Mrs. Whitehead. This led to a delay in the ambulance team accessing the site.

The Directorate has reviewed the formation and functioning of the Incident Response Team and now added the allocation of an Emergency Services Liaison Responder for each ward. This role is allocated on each ward by the nurse in charge as part of every handover at the start of each new shift. This individual functions within the team during normal incident scenarios, however, when a medical emergency is identified, they will immediately go to the main reception, wait for the emergency services to attend, and will escort them immediately to the casualty. This role will also be used in the event of Police or Fire Service support being required and will be allocated to a named individual each shift.

This process has been agreed with inpatient staff members and is identified as requiring allocation on the ward handover sheets (Appendix 6). This will be audited on the inpatient units bi-monthly to ensure compliance, and the outcome of the audit fed back to the senior management team. A copy of initial audit will be made available to share with the coroner's office by end of May 2022.

The management team is committed to learn from these mistakes and have met with the authors to review each recommendation, their thinking behind them, and to clarify all the details that lie behind the report.

By doing this, we have ensured that the actions identified in our Quality Improvement Plan (QIP) effectively respond to the learning identified in the report and are agreed by the investigators, local team based at Millbrook Mental Health Unit and the Directorate leadership team.

Some of the themes are out of the Directorate's sphere of influence and will require Divisional and Trust action. Overall progress of the QIP however, will be coordinated by the Directorate General Manager, [redacted]

We have made efforts to engage with the family and express our sincere apologies. They have asked not to be approached at this point, but as the QIP develops efforts will be made again to share our learning and changes with them.

I hope the information above provides the assurance that we have and continue to consider your recommendations seriously, that we are actively seeking to improve the services we provide by implementing the actions outlined, on which, if you are in agreement, a full update will be made available to you by the end of May 2022.

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[redacted]

Yours sincerely

Dr [redacted]
Chief Executive

Enc *Appendix 1 – NEWS2 Quick Reference Guide*
Appendix 2 – NEWS2 Scenario Training Package
Appendix 3 – Letter detailing learning to inpatient staff members dated 27 January 2022.
Appendix 4 – Trust's policy on Physical Assessment and Examination of patients
Appendix 5 – NHIS wireless network staff user guide
Appendix 6 – Ward handover sheet

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