Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

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[redacted]

Our Ref: [redacted]

Mr Nigel Parsley
HM Senior Coroner, Suffolk
HM Coroner's Office
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1 February 2021

Dear Mr Parsley

Thank you for your letter of 25 September 2020 to Matt Hancock about the death of Susan Warby. I have been asked to respond as Minister with responsibility for hospital care quality and patient safety and as your letter was delayed in coming to the Department's attention, I am grateful for the additional time in which to do so.

First, I would like to say how deeply saddened I was to read of the circumstances of Mrs Warby's death and I extend my heartfelt sympathies to her family and loved ones. I can appreciate how distressing her death must be, particularly as there are serious concerns about the standard of care provided.

We must learn from clearly regrettable incidents such as these and look to make improvements where we can to ensure the safety of healthcare and prevent future deaths.

I am advised that the West Suffolk NHS Foundation Trust acknowledges that aspects of Mrs Warby's care could and should have been better and has apologised to the family of Mrs Warby. I am further advised that since Mrs Warby's death, the Trust has put in place enhanced procedures and safeguards to improve the quality of care and has seen a reduction in intensive care medication errors as a result. Improvements include:

- More robust processes for prescribing and checking fluid bags;
- Introduction of completely clear medication bags;
- Alterations to the way medication bags are supported and displayed when in use to make them easier for staff to read;
- Changes to fluid checking processes in the Intensive Care Unit;
- Improvements to processes so that all bags of fluid are routinely changed every 24-hours; and,
- Implementation of new training on the use of arterial lines.

I am assured that the Trust has reviewed the findings of your investigation to ensure any further learning is captured.

Turning to the matters of concern, in relation to the visual identification of IV fluids that are compatible with use in arterial lines, as you will know from the response by the Medicines and Healthcare products Regulatory Agency (MHRA), guidance has been published for the pharmaceutical industry on how to optimise the presentation of information on labelling so that medicines can be safely supplied and selected to reduce the risk of harm[1].

You will also know that the MHRA has explained that the way in which the containers of the IV fluids described in your report are manufactured (bags composed of polyolefin/polyamide co-extruded plastic), means that judicious use of colour cannot be used within the labelling to aid differentiation and reduce the likelihood of error at the point of selection. The MHRA states that other risk minimisation measures should be employed locally within clinical areas to assist correct identification. However, the MHRA has undertaken to consider further with the marketing authorisation holder whether improvements can be made to the labelling to help ensure the medicine is used appropriately and reduce the likelihood of such errors in future.

In relation to the second matter of concern about training in the correct use of IV fluids and blood sampling techniques, Departmental officials have made enquiries with Health Education England (HEE). I am advised that the insertion and management of arterial lines is a highly specialised skill that is undertaken in a small number of critical care areas in hospitals.

For nurses, this is a post-registration competency for which the employer has a responsibility to provide training. It is not an expected competency for undergraduate nursing. I am further advised that medical students would not be expected to have this competency and it is not contained in the curriculum for medical undergraduate training. The insertion of arterial cannula is contained in a small number of postgraduate medical curricula and the competencies are assessed and monitored through standard educational procedures.

Training in blood sampling from arterial lines is the responsibility of the employer in the first instance and NHS trusts are able to access learning materials already prepared and available through their own local training resources and/or from their relationship with local Higher Education Institutions providing post-registration nurse training.

I hope this clarification is helpful. Education and training are also matters for the relevant professional bodies and my officials have brought the matters of concern in your report to the attention of the Nursing and Midwifery Council and the General Medical Council for their information and consideration.

With your permission, my officials also brought your report to the attention of NHS England and NHS Improvement (NHSEI, the lead body for patient safety in the NHS); the Care

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/946705/Best_practice_guidance_labelling_and_packaging_of_medicines.pdf

Quality Commission (the independent regulator for quality), and the Healthcare Safety Investigations Branch (HSIB).

You may wish to note that the HSIB has reviewed the circumstances outlined in your report, together with another incident that occurred in 2020 in another NHS organisation, against its criteria for investigation and has decided that a preliminary investigation into the use of an appropriate infusion fluid when flushing arterial lines will be conducted.

Finally, you may be aware that in January 2020, the Government instructed NHSEI to commission a rapid independent review into a whistleblowing incident related to Mrs Warby's death. The terms of reference for the review are published online[2]. NHSEI has advised that the review is now expected to be completed by the Spring of this year.

Yours sincerely,

NADINE DORRIES

MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH

[2] https://www.england.nhs.uk/east-of-england/2020/02/07/independent-investigation-to-review-nhs-west-suffolk-whistleblowing/