Sandwell and West Birmingham Hospitals NHS
NHS Trust

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19th January 2017

Mr Z Siddique
H.M. Coroner
Black Country Coroner's Court
Jack Judge House, Halesowen Street
Oldbury
West Midlands
B69 2AJ

Dear Mr Siddique

Re: Regulation 28 Report – Beryl Farmer

I am in receipt of your Regulation 28 Report following the Inquest and your ruling on 23 November 2016, in respect of the late Mrs Beryl Farmer. I should extend again the condolences of the Trust to Mrs Farmer's family, to whom I am copying my letter. We do not accept however that the omissions you cite directly contributed to Mrs Farmer's death.

I note that of particular concern to you was the lack of risk assessment for falls and the absence of sustained neurological observations following her fall which resulted in significant bruising. Equally you have raised concerns regarding our lack of policy on performing CT scans on patients who have sustained a head injury with obvious visible bruising. I share those concerns and have looked into the matter personally. I have also drawn this situation to the attention of my Board operating in public. There is no ambiguity here that we need to do better. We are acting to reduce a likelihood of recurrence.

We have the necessary policies and procedures in place to manage Head Injuries which present in our Emergency Departments. Equally the management of patients who have fallen during an admission is detailed in policies and guidance for staff. These provide both advice and instruction to staff. Having had this material re-checked by our Medical Director and Chief Nurse, it meets both NICE and NPSA standards and remains suitable. It is available to staff

through our Intranet web site. Face to face training time will reinforce this pathway in the months ahead. Additionally we will issue a Patient Safety Notice (an internal safety alert) reminding staff of the importance of neurological observations and the link being made between the management of inpatient falls with a head injury and the pathway.

We are going to amend our inpatient falls policy. This will help us to ensure that post incident monitoring is undertaken. It will also more clearly link our standards in ED and on the wards. It is unacceptable that in this situation the requested monitoring was discontinued. Our use of Vital Pac and the upcoming installation of our new electronic patient record by Christmas 2017 will provide decision support and alerts to reinforce our standards. These changes will be complete by the end of March 2017.

Of course, policies and standards are only functional within a culture which prizes them. As colleagues from NHS England and the CQC are aware, we are currently undertaking work across our medical wards to try and ensure standards are raised. This is based on multi professional team based working, and looking to create a safety culture which is grounded in continuous improvement. This includes, but is not limited to, changed accountabilities at local level, ward based quality improvement time, and monitored board rounds for clinicians to challenge each other's practice. These culture changes take time but the next 12 weeks will see intensive work to try and make the right start.

My colleague, [redacted], Assistant Director of Governance, would be best placed to provide advice to your office on the detail of our plans or indeed to provide such updates as are required on our progress this year. She can be reached on [redacted]

Yours sincerely,

Toby Lewis
Chief Executive

cc Mrs Farmer's family
Care Quality Commission
NHS England
[redacted], Director of Governance
[redacted] Acting Chief Nurse
[redacted], Medical Director