University Hospitals Birmingham
NHS Foundation Trust

Sent by way of email only: [redacted]

Dear Mr Hodson,

Inquest touching the death of Alan Stanley Fallows

Response to Regulation 28 Report to prevent future deaths

I am writing in response to the Regulation 28 notice issued following the conclusion of the inquest on 15 August 2024 touching the death of Mr Fallows who died on 28 March 2024 at Good Hope Hospital (part of University Hospitals Birmingham NHS Foundation Trust (UHB)).

We have carefully considered the concerns raised within your report to prevent future deaths and would respond as follows:

Reporting of incidents retrospectively

You heard evidence that following Mr Fallows' fall on 12 February 2024 an incident report form was not completed at that time and that the incident was reported retrospectively upon an Inquest being opened and statements being requested.

We have been unable to identify why an incident report wasn't completed at the time of the fall as the member of staff has retired however retrospectively reporting an incident is expected if the incident had not been reported at the time.

An analysis of reporting data based on a 12 month period of falls across UHB demonstrates that falls were reported:

a) Same day – 86.4%

b) The following day – 98.4%

c) Within 2 days – 99.1%

The above data provides assurance that most falls are reported within 2 days. Whilst the data is reassuring, we have updated the training provided by our falls team to reinforce the reporting requirements following a fall.

Automated approval of incident

During the Inquest you raised a concern in relation to an automated approval and sign off process of incidents. In this case, the incident report relating to Mr Fallows fall on 12 February 2024 recorded the final approver as 'automated' which was in contrast to Mr Fallows second fall which included details of a named 'final approver'.

All reported incidents are reviewed by an individual before the approval and sign off/closure process. We do not have an automated approval and sign off process for incidents and all incidents are closed following review by an individual. For low level incidents, such as the incident relating to the first fall where the level of harm is low, these incidents are closed following review by a local manager. Following this review an automatic closure process is run which 'stamps' the record with the final approver as 'automated'.

Where the level of harm is moderate or above, these are reviewed by a member of the Clinical Governance and Patient Safety team prior to closure and the governance lead within this department will be named as the final approver.

In all cases, there is a manual review before an incident is closed.

In addition to the above review, our falls team review every incident report form, relating to a patient fall, on a daily basis. The team review the incident, the patient record which includes a review of the post-fall assessment, to identify if there has been patient harm. The incident report form is also reviewed by the senior nurse/ward manager which ensures there is appropriate review following a patient fall.

Use of templates when completing DATIX reports

You heard evidence from the Senior Ward Sister that nursing staff utilise templates or pro-forma text when completing DATIX reports [incident reports] and you are concerned that this approach may lead to incorrect or incomplete information being recorded.

We can confirm that we do not have a template list of actions for incident report forms. Within our electronic patient record there is a post-fall section in the daily care plan which includes a number of actions that staff must take following a fall which includes; ensuring that neurological observations have been commenced, ensuring that an incident form has been submitted, ensuring that the Next of Kin have been informed etc. In this case the Senior Sister used a set list of actions to ensure all necessary falls prevention interventions were in place. I can provide assurance that templates are not used.

In addition to the above, the daily review of incidents undertaken by the falls team acts as an additional independent individualised review.

I would like to assure you that the concerns raised within the Regulation 28 Report have been thoroughly investigated and I hope the information provided above provides reassurance to you of the processes that are in place.

Yours sincerely

[redacted]

[redacted],

Deputy CEO and Chief Medical Officer