University Hospitals Birmingham
NHS Foundation Trust

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11th December 2024

Mrs Louise Hunt
HM Senior Coroner for Birmingham and Solihull

By way of email only: [redacted]

Dear Mrs Hunt

Inquest touching the death of Mrs Joan Knight
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 21 October 2024, into the death of Mrs Joan Knight at Queen Elizabeth Hospital Birmingham (part of University Hospital Birmingham NHS Foundation Trust). I extend my sincere apologies to Mrs Knight's family.

I note your narrative conclusion was that Mrs Knight died from the consequences of a recognised complication following treatment for severe coronary artery stenosis.

I further note your concern regarding the risk of future deaths, which has been addressed below. The focus of the actions has been at the Queen Elizabeth Hospital Birmingham (QEHB) but the learning identified in this response has been shared with each of the responsible Hospital Medical Directors and Directors of Nursing covering QEHB, Birmingham Heartlands Hospital and Good Hope Hospital respectively for implementation.

We have carefully considered the concerns raised within your report to prevent future deaths, relating to the conduct and recording of mortality reviews.

Concern:
The mortality review that was undertaken in this case was completed incorrectly and contained contradictory terms about whether the death was avoidable. This raises a concern that mortality reviews are not being concluded correctly and that there could be inadequate learning from cases raising a risk of future deaths.

As part of our disclosure to you for the inquest we provided a copy of the mortality review completed by the speciality responsible for Mrs Knight at their M&M meeting.

Following review and discussion with the speciality we have learnt that they are one of only two specialties still using legacy IT software (Dendrite) for capturing mortality reviews. The software allowed the input of multiple methodology coding scores for recording; Quality of Care, Preventability and Categorisation/Nature of Death, which could potentially appear contradictory.

We have taken the following immediate steps to rectify this concern and reduce the likelihood of reoccurrence:

1. We have requested that the speciality use the three methodology coding scores recommended by the Learning from Deaths Team in line with the rest of the Trust and we have disabled the use of all other methodology coding fields on the software.
2. We have identified the specialities within the Trust who are currently using the Dendrite software for capturing mortality review. (Cardiology plus one other speciality, both on the Birmingham Heartlands Hospital site)
3. A new Mortality & Morbidity recording platform has been developed and is to be piloted prioritising the two identified specialities using the Dendrite software.

In addition, the following planned steps are due to be completed within the next 12 months:

1. A New Mortality & Morbidity recording platform is to be rolled out across the remainder of the Trust once piloted.
2. Updated Mortality & Morbidity standards are to be published and readily available on the Trust intranet.
3. The introduction of a Trust Mortality Committee, commencing in December 2024.

I would like to assure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously, which I hope is demonstrated in the steps we have taken in reviewing and strengthening our systems, processes and training provision to our teams.

Yours sincerely

Chief Executive