University Hospitals Birmingham
NHS Foundation Trust

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Mrs Louise Hunt
HM Senior Coroner for Birmingham and Solihull

By way of email only: [redacted]

Dear Mrs Hunt

Inquest touching the death of Mr Robert Taylor
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 Mr Robert Taylor at Birmingham Heartlands Hospital.

We have carefully considered the concerns raised within your report to prevent future deaths and our response is set out below.

1.The central issue in this case relating to the fall on 11/06/24 was the lack of enhanced nursing observations. The Nursing witness was unable to say what steps, if any, had been taken to try to put enhanced observations in place. The Investigation report stated that enhanced observations had been identified as needed but did not expand on what actions were taken, if any, to obtain enhanced observation nor what actions had been taken after the death to ensure enhanced observations for patients that require them. This raises a concern for future deaths.

Within the original learning response (After Action Review) it was identified that the fall in this case was multifactorial and advised that staff were unable to provide enhanced care to Mr Taylor within the 'what could have gone better' section. There were several factors identified within the learning response that contributed to the difficulty in being able to provide enhanced care. Staffing levels in relation to the challenging geography of this ward, including the large number of side rooms, was a contributory factor in the lack of ability to provide enhanced care. This ward, not accustomed to conventionally receiving a high level of patients requiring enhanced care, did receive a substantial number of patients needing enhanced care at the time, making it even more difficult for this need to be met within the staffing model which did not consider the unique geography. The creation of a group to review pathways and allocation of patients across acute medicine, as in the action plan, will improve the ability to meet the need for any given acute medicine ward to provide enhanced care. Whilst the original learning response does include actions to address these points it is accepted that witnesses at the inquest should have been able to explain these points and what had already been put in place.

There will be a nursing workforce review to cover the points above. It is accepted that this point should have been more explicit within the report and details of the actions set out below should have been included.

By way of assurance on actions to address the concerns raised around enhanced care as set out in the action plan in the learning response, the following progress has been made to date:

- The Enhanced Care policy has been re-embedded into the ward and risks are discussed in the ward huddle following shift handovers.
- Acuity was noted to be a contributing factor within this case. There is currently a SNCT (Safer Nursing Care Tool~~)~~ to review of acuity levels as part of the wider Trust review of acuity and dependency. Whilst this work progresses increased staffing needs will be identified on a case-by-case basis as per the UHB enhanced care policy. Staff will be requested through UHB clinical bank services in a timely manner and explored on a shift-by-shift basis.
- The nurse in charge currently identifies and discusses patients at risk of falls, as well as those requiring enhanced observations, with the Matron, prior to the 0800-touchpoint meeting. Since the inquest we have made changes in how this information is communicated. There is a more risk focused approach being taken and a focus on vulnerable patients in higher risk environments. If a ward area is unable to provide assurance that a risk is being mitigated, then additional safety measures to ameliorate the risk are put into place. Examples include:
    - Discussion in the morning safety huddle regarding risk of falls and patients for whom there is concern.
    - Reorganisation of workload to mitigate and reduce risk
    - Movement of patients into more appropriately positioned side rooms where possible.
    - Intermittent checks completed on patients within the side room with documentation, including:
        - Ensuring that beds are placed in the lowest position possible
        - Nursing call bells within reach
        - Anti slip socks for mobile patients
        - Walking aids within reach
- We have recognised that the current layout of ward 19 can be challenging when nursing patients who are at risk of falls because of having only two 6 bedded bays and 13 side rooms positioned in a T shape within the ward. In addition, only 4 side rooms have partial views (if the door is open), the other 9 have no visibility.
  We have spoken to the senior nursing team in charge of the assessment area regarding environmental challenges and provided a visual map of side rooms, so they are aware of the physical layout of the ward. We have asked the assessment areas when allocating patients to be mindful of ward geography and communicate any concerns and risks that patients have such that plans can be put in place to support enhanced care and risk of falls.

  In the longer term, a wider piece of work is being planned for January 2025 to review side room utilisation. This will allow us to place the right patients into appropriate side rooms with a commensurate reduced risk of falls.

- Following the death of Mr Taylor the department is currently delivering falls training, which is provided by the Falls team and has been attended by qualified nurses and health care support workers. To date 42.5% of ward staff have completed training with a further 40% of staff booked on to the training for December 2024. The remaining staff will complete training by the end of January 2025.

- Ward monitoring of lying and standing blood pressure has met the trust standards of 75%. On-going monitoring will continue to monitor compliance and safety huddles are reminding staff to review patient's lying and standing blood pressure on admission or review this when clinically indicated.
- In addition, we are completing a trial of alarmed falls beds and exploring long term solutions with falls seats and bed alarm pads.
- Verbal feedback following the outcome of the original AAR (After Action Review) was given to staff in relation to completing falls risk assessments on admission and reviewing the risk of any changes in clinical condition. This is also discussed during the morning safety huddles with staff. A review of compliance has been undertaken and shows significant improvement in the completion of falls risk assessments within the 6 hours target and the ward are currently exceeding the Trust current compliance of 83.2% at 87.4%. Ward 19 have shown a sustained improvement month on month with July being 68.6% and November at 87.4%, giving an 18.8% improvement. Ongoing monitoring of compliance with this standard is taking place to ensure continuous improvement is sustained.

2. The witnesses and the investigation report did not address the central issue relating to the fall and this raises a concern about the quality of post death investigations being undertaken by the Trust. This raises a concern for future deaths.

As part of a drive to improve patient safety within the NHS, all Trusts have adopted the NHSE Patient Safety Incident Response Framework and within that framework learning responses [investigations] are to apply a systems-based approach to identify any learning.

It has been identified that a nursing witness was identified shortly before the inquest. This resulted in the nursing witness attending without having the opportunity to submit a witness statement which would have otherwise supported them with answering questions. This has been acknowledged as an oversight on behalf of the Trust on this occasion, as our usual practice is to identify witnesses earlier on in the process to ensure that they have adequate time to prepare for an Inquest.

Since the inquest the Lead Nurse for falls has worked with the legal service team to revise the templates used for the nursing witness statement to ensure that witnesses are capturing essential information in relation to a fall to assist the Coroner at Inquest. The template provides additional prompts to enable the witness to write a logical account of the incident, including the patients care leading up to the fall, how the fall occurred, and post fall care, including any learning identified.

In addition, our Legal Services Team will ensure that specialist nurse leads for the Trust, for example those involved in Falls and Tissue Viability, will be involved from the start of a Coronial investigation or inquest process to ensure they have full awareness of issues and can contribute to an investigation from a highly experienced professional standpoint.

Regarding witnesses summonsed to attend inquests, the Legal Services Team are ensuring that our staff are fully prepared to attend an inquest by arranging individual and group meetings and telephone calls with witnesses and their managers together with meetings with our instructed solicitors to ensure that staff are supported and are as prepared as fully as they can be to give evidence at the inquest. In addition, a series of training for ward managers and nursing staff is being rolled out commencing early next year across all our hospital sites.

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 that have been taken following Mr Taylor's death.

Yours sincerely

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Chief Executive