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2nd December 2024

Private & Confidential
Mr Ian Potter
Assistant Coroner
Coroner Area Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Dear Mr Potter,

RE: Regulation 28 Prevention of Future Deaths Report: Ian Hegarty, Ref 2024-0583

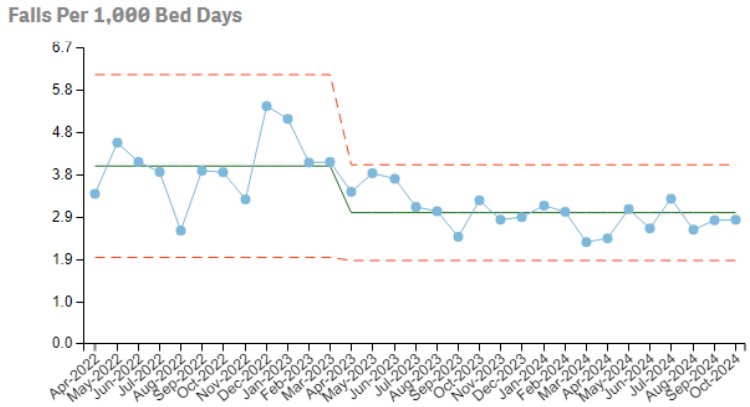
I write in response to the inquest dated 23rd October 2024 and the Regulation 28, Prevention of Future Deaths report to the trust dated 28th October 2024.

We are sorry that Mr Hegarty died at the Royal London Hospital after a fall that caused him to sustain a fractured neck of femur. At the time of his fall, nursing staff reported it as an incident on our risk management system, Datix, and it was then reviewed under the Patient Safety Incident Response Framework (PSIRF). We have taken his fall very seriously and as discussed at the inquest, we are undertaking a Patient Safety Incident Investigation (PSII).

PSII's are undertaken to identify opportunity for learning and improvement through providing a clear explanation of how the organisations systems contributed to his fall. This is currently being undertaken by senior investigators at the Royal London Hospital. We have allocated a member of staff as the compassionate engagement lead to support Mr Hegarty's family through this process and to ensure that they can be involved in the investigation process as they wish.

Once the investigation is complete, the findings from the PSII will be used to identify actions that will lead to improvement in the safety of the care future patients will receive. Agreed actions will be recorded on Datix, so that their completion can be tracked. His family will be offered a copy of the report to see the action that will be taken.

I would like to assure you that falls are a patient safety priority for the hospital and we have a Quality Improvement workstream in place for reducing the number of in-patient who fall during an admission. This is led by one of our Associate Directors of Nursing with support from the hospital Quality Improvement team. It feeds into our Harm Free Care agenda where we are encouraging all our clinical teams to share learning so that improvements are made across all our in-patient wards. This chart shows the reduction in falls that we are continuing to see at the Royal London Hospital and that we are continuing to monitor monthly through the Safety Committee and performance reviews:



Once the investigation into Mr Hegarty's fall is completed, the learning will be discussed as part of this improvement workstream. While this investigation is on-going, I would like share the assurance plan for the Specialist Medicine division. This was developed in April 2024 and is focusing on several areas of improvement including the assessment of falls and enhanced care. Please find the document attached.

I hope this provides you with the assurance that we have taken the events in Mr Hegarty's care very seriously but I would be very happy to discuss or clarify any of the above points if you wished.

Yours sincerely

[redacted]

[redacted]
Chief Medical Officer

Appendix – Specialist Medicine Division Assurance Plan

No.	Safety action description (Enter in the form of a SMART Aims statement)	Measure of performance	Action owner	Target delivery date	Planned review date
1.	Reflective discussion with MDT • Discussed incident • Reporting of falls – medical & nursing • Post fall assessments & care • Nursing assessments on admission (reviewed and updated as necessary) • Roles & responsibilities within the team on a shift • Induction of bank shift (per shift and on introduction to the bank) • Communication with relatives • Any barriers to the above • Any training/support needs identified	Meeting attended by staff involved and completed. Attendance recorded.	Deputy AdoN	Completed 17/4/24	Completed
2.	After Action Review • As per PSIRF protocol, led by independent Consultant	AAR process in place and signed off at Divisional level	ADoN	Completed 2/5/24	Completed
3.	Weekly documentation audits & action plans • Weekly assurance meetings with AdoN/Deputy AdoN • Attended by Senior Nurses/Ward Managers/ Matrons/Practice Development Nurses for all 6 wards within the division • Weekly submission of documentation, assessments & care plans for all fundamentals of care • Action plans devised by each ward in response • Metrics are stored in teams folder to share with MDT/ward teams	Assurance that 100% of assessments are completed. A consistent improvement in metrics reviewed weekly. Robust action plans in place for training and development.	ADoN	December 2024	Weekly
4.	Training, Falls and Enhanced Care risk assessments • Senior nurse oversight of enhanced care • Focus on ward based training re: falls assessment, post fall assessment & care	Assurance by Senior Nurse that all members of staff have a refresher session on documentation training	Senior Nurse & Practice Development Nurse	December 2024	Weekly
5.	MDT ward meeting monthly	Meeting minutes and action log	Clinical Lead & Senior Nurse	Commenced July 2024	Weekly

	• Governance discussed e.g. risks/incidents/staffing/staff wellbeing • This incident was discussed at length				
6.	M&M MDT meetings • This incident discussed at length in M&M.	Meeting minutes and action log	Clinical Lead	Existing meeting	Monthly
7.	Clinical incidents to be discussed in medical/ nursing handover • Daily board round to discuss incidents within the last 24 hours • Debrief and immediate actions implemented	Handover documentation	Consultant/ AHP/ Ward Manager	Commenced May 2024	Weekly
8.	Mid shift safety huddle • Implementation of mid shift safety huddle around 2pm. Focus on patients who are at risk of falls/ acutely unwell/ pressure ulcers/ nutrition & hydration needs. Staff can escalate any concerns or training needs. Supernumerary nurse in charge to provide support	Daily mid shift safety huddle in place	Senior Nurse	Implemented June 2024	Monthly
9.	QI project focussing on handover – nursing/medical/AHP. Can these be combined/reviewed? • QI project to commence reviewing ward handovers – medical/nursing and AHP • Review documentation and white board processes • Can these be combined to ensure a robust MDT handover?	Completed QI project with recommendations for improvement	Matron	Commenced August 2024	Monthly