Royal Free London
NHS Foundation Trust

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Private and Confidential
His Majesty's Assistant Coroner Mr. Ian Potter
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Via Email

14 April 2025

Dear Sir,

Re: Regulation 28: Prevention of Future Deaths report – Carl Edmond Eastman (date of death: 28th July 2024)

We write to you in response to the Regulation 28: Prevention of Future Deaths report following the inquest into the death of Carl Edmond Eastman.

We would like to reiterate our sincere condolences to the family of Mr. Eastman for their loss.

The Royal Free London NHS Foundation Trust has carefully considered the matters of concern raised in the Regulation 28 Report. We note that consultants and nursing representation involved in the case submitted written statements, gave evidence at the inquest, and the Trust provided an action plan.

We are grateful for the opportunity to respond to the matters you have raised and would like to start by assuring you that three safety event review meetings took place, as part of our routine governance process, prior to the inquest. The Trust reviewed this safety event at the Patient Safety Event Review Panel (PSERP) on 14 August 2024, where it was agreed that an After-Action Review (AAR) would be undertaken. The panel identified concerns surrounding break times and cover during the night on the ward, in addition to education regarding the Trust falls policy. Following the AAR, a robust action plan was presented to the PSERP panel by the senior ward and clinical team on 18 September 2024, and several immediate actions were implemented, which are outlined within this response.

The inquest took place on 17 December 2024 and raised several matters of concern which have been responded to in turn below:

"1) The consultant geriatrician's evidence was that CT scan was requested to take place 'as soon as possible' following the first unwitnessed fall on 25 July 2024; however, they accepted that this was not conducted in a timely manner.

Further, following the second unwitnessed fall on 28 July 2024, there was a further delay in a CT scan taking place. I was told that this scan should have been conducted within 1-2 hours

of the request being made, yet it took place over three hours after the patient was reviewed by the doctor and the request for the scan was made.
In Mr Eastman's case, the delays in receiving the scans transpired to be immaterial in the particular circumstances. However, I am concerned that if delays in such scans, where traumatic injury is suspected, are repeated in the future, there is a risk that deaths could occur"

The Trust acknowledges that the scan being performed approximately 12 hours after being ordered on 25 July 2024, was not timely. In response, a review of the National Institute for Health and Care Excellence (NICE) treatment guidelines for patients presenting to the Emergency Department (ED) following a fall will be undertaken. This review will ascertain necessary improvements to the timeliness of image reporting for inpatient falls to support the earlier identification of any suspected injuries for treatment, and ongoing management to prevent any further deterioration to patients.

"*2) There was evidence of what I considered to be 'widespread communication issues' in the care provided to Mr Eastman*.

"When the on-call doctor attended to review Mr Eastman at approximately 02:45 on 28 July 2024, ward staff (incorrectly) told the doctor that nobody had fallen on the ward, which lead to the doctor leaving the ward without Mr Eastman having been reviewed. As the consultant geriatrician said in his evidence, communication between the ward staff and medical staff was not good."

At the time of Mr. Eastman's second fall on 28 July 2024 at 01:00, the nurse looking after the patient contacted the doctor on duty to review the patient following the safety event, as per the Trust Falls Protocol. Unfortunately, the doctor attending the ward was not provided with the details of the patient for review. Furthermore, the nurse looking after the patient was on a break and failed to communicate the requirement for a doctor to review Mr. Eastman to the nurse covering this role. The doctor was unable to identify the patient upon attending the ward, and the patient was regrettably not reviewed; therefore, the patient's deterioration and injury sustained in the fall were not identified in a timely manner.

It is acknowledged that discussions concerning the patient's condition could have been more thorough and this failure to communicate effectively has been taken extremely seriously by the teams involved. Communication amongst the nursing and medical teams is of the highest priority to the Trust, and immediate actions have been taken following this safety event to improve key elements of the ward-based and wider hospital communication. It has been identified that the implementation and education of the Situation, Background, Assessment and Recommendation (SBAR) method of communication, will enable the multi-disciplinary teams to ensure effective and precise information sharing in critical safety events such as Mr. Eastman's. Implementation of this communication tool will commence in ward-based induction plans for nursing teams, and education will be provided at the junior doctors' induction. It will also be embedded during ward safety huddles, board rounds and medical discussions.

Further immediate actions were taken following the incident on Ward 8 West, to resolve the communication issues identified, as follows:

- Ward break restructure during the night with an effective handover process, to always ensure clear communication within the ward nursing team.
- Introduction of an additional mid-shift ward safety huddle on the ward to include a review of patients at high risk of falling, and any changes in a patient's condition at all

safety briefings. These safety huddles are scheduled take place at regular intervals throughout the day at 07:30, 13:00, 19:30 and 00:00.

In addition to these immediate measures, and to ensure all inpatient falls are reviewed and escalated in a timely manner, wards are required to report all inpatient falls through the hospitals bed and site management team between the hours of 19:30 and 07:30. The bed and site management team will have knowledge and oversight of all inpatient falls, and patients who are not reviewed by a doctor within 1 hour will be escalated through this team.

As part of ongoing education for medical and ward nursing teams, emphasis will be placed on the importance of the Trust's falls protocol at night, which will be included and provided to nursing and medical teams, in conjunction with the hospital at night Standard Operating Procedure (SOP).

"The evidence revealed that there were deficiencies in basic record keeping."

A review of the medical and nursing notes identified gaps in documentation. The Trust is committed to improving this and is in the final stages of approving changes to how falls assessments, interventions, care planning, and post-fall care are recorded in all patients' medical records within Electronic Patient Record (EPR). Accordingly, the updated falls assessment will be completed in EPR when a patient is admitted to the ward, after any inpatient fall, or if there are changes in their medical condition.

This update to the current falls assessment meets the standards set by the Royal College of Physicians' National Audit of Inpatient Falls and follows NICE guidelines. Staff will receive full training on the new documentation process to ensure that assessments are taken, appropriate interventions are made, and accurate records kept. Clinical Practice Educators (CPE) will support this transition in all wards areas to ensure the updated falls assessment is implemented.

Compliance on the completion of these audits will be monitored through an action plan and quarterly audits, with results reported to the Trust Falls Steering Group. Oversight of this data will be provided in the Clinical Performance and Patient Safety Committee (CPPS), chaired by the hospital's Medical Director and attended by senior divisional leaders.

"3) *As set out above, there was clear evidence that the Trust has put extensive measures in place to address the issue of staff having not followed the Trust's own post-fall procedures and protocols. However, I am concerned that the issue may not be limited to just those particular protocols and may be indicative of a wider skills/knowledge deficit*."

There is agreement that a robust and sustainable education plan for falls must be implemented. Following the death of Mr. Eastman, a post falls simulation programme was developed and is in the process of being delivered to all nursing staff. All Clinical Practice Educators have been trained as champions to deliver the falls simulation training to ward staff. Progress of the establishment of this body of work is currently being monitored though the Senior Nurse Matrons' meeting which takes place weekly, and all areas involved are required to report progress of this implementation by early May 2025.

"4) Following on from the matter set out in paragraph 3 above, the evidence revealed a lack of professional curiosity on the part of some staff members (nursing and medical). In my view, this could also be indicative of an underlying skills/knowledge deficit"

A thorough review of this safety event identified key areas of learning detailed in the action plan provided; it has highlighted the knowledge gaps in the Trust falls protocol across the nursing and medical teams, and significant work has been undertaken to resolve this issue. Falls simulation training in ward areas, which will include nursing and medical teams, to build awareness of the Trust falls protocol, post fall management and falls prevention is in the final stages of implementation and provides wards with tools and scenarios to ensure training in this area. This training also reinforces the importance of documentation, escalation methods and timelines. As previously mentioned, ward areas are expected to report their progress on implementation of this in early May 2025. Weekly governance meetings take place to review safety events with governance leads, ward managers, matrons and clinical leads in attendance, to ensure immediate learning is captured and shared with appropriate teams in an effective and timely manner.

The review also identified that there was limited education for medical teams on the Trust falls protocol, education and post falls management; this will now be included in the junior doctors' induction education.

The Trust is committed to fully cooperating with all coronial investigations and keeps its processes for doing so under continual review. We hope this letter reassures you that Mr. Eastman's death was investigated and presented at the Royal Free Hospital's Patient Safety Event Review Panel (PSERP), prior to the inquest. Additionally, there has been a careful review of his care again as a result of your report.

The Trust is committed to learning from Mr. Eastman's tragic death and continuously improving patient safety. We will actively monitor adherence to the ongoing improvement plans and the Trust's action plan is set out below. This will be monitored by the AMEDEC Divisional Quality & Safety Board and the Clinical Performance and Patient Safety Committee.

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Action Plan

Action ID	Concerns raised	Action / Response	Owner	Action Deadline	Evidence if necessary
1.	Wider Skills/ knowledge deficit	a. The Royal Free Hospital site has made changes to the way it delivers ward training by introducing falls prevention simulation training, which will be provided regularly to clinical staff by the Clinical Practice Educators (CPE). Currently, all CPEs have been trained, and training education has been established and will continue with all members of staff. Furthermore, a case study based on this safety event will be used for the purpose of this training. The programme entails regular refresher education and simulation sessions for all clinical areas to ensure that all staff are educated. This will ensure that falls prevention remains a priority and falls avoidance strategies and falls management is streamlined and that the relevant governance reporting and analysis processes continue. b. The Medical Education programme for resident doctors to include falls assessment, education, and post fall management.	Divisional Director of Nursing AMEDEC, in collaboration with other divisional directors of nursing Head of Medical Education	30 June 2025 31 August 2025	Training Programme outline Attendance List of trainees CPE training pack and Programme outline Training Programme outline
2.	Communication	a. Education programme for use of SBAR to be included in ward local inductions; PARRT will assist with this ongoing training. b. Matrons and Ward Managers to outline to nurses in charge (NIC) the staff break time structure, particularly on high acuity wards with enhanced care requirements. NIC expected to oversee breaks, demands and acuity of the ward for better utilisation of staffing resource cover. Spot checks will be undertaken by Matrons/ Head of Nursing to ensure embedding of this structure.	Heads of Nursing/ Matrons for all divisions Ward Managers	31 October 2025 Completed	Training records Nurse in charge SOP

		c. Implementation of mid shift huddles on 8W ward. Learning from this event will be shared with other wards.	Ward Managers	Completed	Email to confirm completion
3.	Documentation	a. EPR documentation for falls assessment, interventions, and post fall management to be updated. b. The importance of documenting falls assessments, interventions and post fall management will be reiterated to all ward staff. c. Compliance with documenting the falls assessment, interventions and post fall management will continue to be monitored through the Trust falls steering group. d. A Safety Bulletin will be sent to all staff Trust-wide, reminding them of the importance of documentation in relation to falls.	Falls Lead Head of Nursing AMEDEC in collaboration other divisional directors of nursing Ward Managers/ CPEs Head of Patient Safety and Risk	31 August 2025 01 May 2025 31 October 2025 25 April 2025	Evidence of implemented change in EPR Agenda from monthly divisional governance meeting, and minutes from senior nurse/matrons meeting Monthly Audit to include Power BI and Tendable Copy of the Safety Bulletin uploaded to Freenet
4.	Delays in CT scan	Review of the National Institute for Health and Care Excellence (NICE) treatment guidelines for patients presenting to the Emergency Department (ED) following a fall.	Trauma Lead for AMEDEC	31 July 2025	Emails and amendment to guidance (if applicable)

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We will be sending a copy of this letter to North Central London Integrated Care Board.

If you would like any further information about any part of this letter, please do not hesitate to contact us.

Yours sincerely,

[redacted]

Director of Nursing,
Royal Free Hospital
London Group NHS Trust

[redacted]

Medical Director
Royal Free Hospital Royal Free
Royal Free London Group NHS Trust