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National Medical Director
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8 April 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Philip John Unwin who died on 3 April 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 February 2025 concerning the death of Philip John Unwin on 3 April 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Philip's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Philip's care have been listened to and reflected upon.

Your Report raised the concern that Royal Stoke University Hospital's current model of staffing within its Emergency Department (ED) Resuscitation area is not in compliance with national guidance, and that recommendations made by an internal patient safety investigation into Philip's care have not been implemented.

NHS England has engaged with Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), the responsible commissioner for Royal Stoke University Hospital's urgent and emergency care services, on the concerns raised.

The ICB advise that the hospital's Patient Safety Incident Investigation (PSII) focused on the issue of failure to manage a deteriorating patient, alongside exploration of the current model of care for medical patients within the ED. The investigation found that while nursing staff did undertake timely and appropriate escalations of care to the various medical teams, it was apparent that robust medical ownership of Philip was not optimal, leading to delayed escalation to the Intensive Care Unit. From an organisational viewpoint, it was found that the model of care at the time contributed to the lack of timely medical intervention for Philip.

Actions taken to mitigate this risk occurring in the future have included:

- The development of a clear process to clarify the escalation process in the ED, which will provide assurance that for any patient deteriorating with the ED footfall there is a clear escalation process for medical and nursing staff.
- The development of a process to "ring fence" beds in the Acute Medical Unit for acutely unwell patients in the ED who need to be brought to the AMU in a timely manner.

NHS England understands that University Hospitals of North Midlands NHS Trust (UHNM), which Royal Stoke University Hospital is a part of, is in the process of reviewing ED resuscitation staffing numbers.

UHNM advise that having a Named Nurse in the ED has been tried previously at the Royal Stoke University Hospital, but a 'team approach' has been found to work better in the Resuscitation area of the ED rather than care falling to one medical professional. Trauma patients are always nursed 1:1 and this is due to the professional judgement required and the ability to flex staff around the department and into resuscitation with the support of an Operating Department Practitioner (ODP), the (supernumerary) Nurse in Charge and any outreach support for trauma calls. UHNM have asked us to note that the PSII identified that there was clear escalation by relevant nursing staff, and that it is not their belief that a lack of nursing staff led to the failure to recognise Philip's deterioration.

It is appropriate that UHNM provide any further comment regarding the Coroner's concerns. It is NHS England's understanding that they will be providing further information on actions taken by the Trust since the inquest into Philip's death in their response to the Coroner.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Philip, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director