University Hospitals of North Midlands NHS Trust

Trust Ref: [redacted]

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14 April 2025

STRICTLY PRIVATE & CONFIDENTIAL
Mr Daniel Howe
Area Coroner
Stoke on Trent and North Staffordshire

Sent via email: [redacted]

Dear Mr Howe

Phillip John UNWIN

Further to your letter dated 19 February 2025, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013, addressing your concerns surrounding the death of Phillip John Unwin.

Recorded Circumstances of the Death

Mr Unwin was a 68 years old gentleman who was admitted to Royal Stoke University hospital on 2 April 2024 at 00:45 due to fever, shortness of breath and chest pain. He was commenced on broad spectrum antibiotics within an hour of his arrival for suspected sepsis due to Urinary Tract Infection although it was subsequently confirmed that sepsis was secondary to pneumonia.

He remained in the resus area of the Emergency Department despite a progressive deterioration in his condition and escalations from the nursing team to the medical team for him to be reviewed.

Transfer to ICU was not initiated until approximately 14:30 at which time he was noted to be acutely unwell and in peri arrest. After being transferred to ICU at approximately 16:00 supportive intervention including sedation, ventilation and vasopressor medication failed to reverse his condition, and he passed away in hospital on 3 April 2024 due to multi organ failure secondary to pneumonia.

Concerns

During the course of the inquest, you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows.

Although the conclusion of the inquest was one of Natural Causes there was evidence of a failure for medical teams to respond to concerns that the patient was deteriorating whilst awaiting assessment in the resuscitation area of the Emergency Department of Royal Stoke University Hospital. It was accepted by witnesses from the hospital that the patient should not have deteriorated to a 'moribund' state within that area of the hospital when concerns had been raised by staff and family, and that review and escalation to intensive care should have been initiated sooner (albeit the evidence was that this did not more than minimally contribute to the death).

[redacted]

As a result of the concerns raise by hospital staff regarding missed opportunities to escalate care in a timely manner the hospital undertook a Patent Safety Incident Investigation (PSII). As a result of that investigations a number of recommendations were made with assurances given to the report author that work is being undertaken to review and amend policies and procedures focused on reviewing, escalating and referring deteriorating patients.

However, the inquest was told that although the Emergency Department Resuscitation area was where the illest patients were placed awaiting review, staffing levels were not in compliance with national guidance. The Royal College of Emergency Medicine (RCEM) "Nursing Workforce Standards for Type 1 Emergency Departments" (Appendix 5) states "There will be a minimum of Registered Nurse to each patient in the resuscitation area". The recommendation continued that there should be a named nurse allocated to each patient which should be 1:1 as per National Guidance.

The concern is that the current model of staffing within the Emergency Department Resus area is not in compliance with national guidance and the recommendations following internal investigation into the care afforded to the deceased have not been acted upon in this respect.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013.

In your opinion, action should be taken to prevent future deaths.

Action Taken

The University Hospitals of North Midlands NHS Trust has taken the issues highlighted during the inquest seriously and indeed, I am grateful that you have raised your concerns to which a response is provided below.

It is correct that the Royal College of Emergency Medicine (RCEM) Nursing Workforce Standards for Type 1 Emergency Departments states that "there will be a minimum of a Registered Nurse to each patient in the resuscitation area.

The recommendation also provides that there should be a named nurse allocated to each patient, as per National Guidance.

Royal Stoke Hospital has a Type 1 Emergency Department and has a total of 8 cubicles in the resuscitation (resus) area, however the team try to keep resus at a maximum of 6 patients leaving 1 space for paediatric emergencies (and when in use paediatric nursing staff from Children's Emergency Department attend), and 1 cubicle space for any trauma patients. There are always 4 Nurses who are allocated to the department for each shift in resus and then the department flexes our nurses to cover all Emergency Department Areas, flexing into the area with the most need at the time.

Additionally, there is a Operation Department Practitioner (ODP) in the department who supports resus during the day, and we also have the 'outreach team' who will attend resus whenever there is a trauma call. When acuity or resus capacity is high, the Nurse in Charge (NIC) both supports and makes appropriate staff moves from across the whole of the department, increasing both trained and untrained presence in resus on a continual prioritisation of need.

The overall nurse staffing numbers for the whole of the Emergency Department allow for a degree of flexibility across the department to wherever the greatest need is at any one time. Professional clinical judgement allows for this decision making, and the NIC remains non-clinical to flex staff as required.

[redacted]

RCEM guidance is not mandatory and the given the size of the ED at Royal Stoke, our ability to flex our nursing team during times of surge, escalation and need is preferred by our ED team on the ground and the leadership Triumvirate. This means we continually prioritise through the non-clinical Nurse in Charge so as to understand need, and then flex according to skill and priority across our ED.

We previously trialled a ‘named nurse’ approach within resus and the team felt this lacked flexibility as they used an ‘allocated nurse’ based on patient need and skill-set per shift but, following further review, we have decided to structure this and reinstate this model to include a ‘named nurse’ within our resus from early April 2025. The named nurse model will then be audited/monitored via our internal review processes and as part of the Integrated Care Board (ICB) reviews of our Emergency Department.

We do hope that the above information provides assurance that the Trust has taken the concerns raised at the inquest seriously and that both you and Mr Unwin’s family are content with the response that has been provided.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

[redacted]

Chief Executive