NHS
South Tyneside and Sunderland
NHS Foundation Trust

Chief Executive: [redacted]

Ref: [redacted]

6 May 2025

Sunderland Royal Hospital
Kayll Road
Sunderland
Tyne & Wear
SR4 7TP

Tel: 0191 565 6256 ext 42404
Direct tel: 0191 569 9688
www.stsft.nhs.uk

PRIVATE & CONFIDENTIAL

Mr D Place
Senior Coroner for the City of Sunderland
City Hall
Plater Way
SUNDERLAND
SR1 3AA

Dear Mr Place,

Dear ~~Mr~~ Place

Regulation 28 Report to Prevent Future Deaths – Mr Allan Taylor

I write further to your correspondence dated 11 March 2025 regarding your concerns identified during the Inquest into Mr Taylor's death.

Our internal investigation identified omissions in care regarding the level of observation in place for Mr Taylor and the lack of escalation of concerns. Actions were undertaken to address this issue; an urgent review of the existing Enhanced Interactive Care and Observation (EICO) guideline took place which has now been amended and renamed Enhanced Therapeutic Observation and Care (ETOC) for patients in line with recent national changes in guidance as recommended by NHS England. In addition to exploring best practice nationally, the review of the guideline also took into consideration how other local Trusts manage safe observation and care of patients.

This amended guideline (please see attached draft) has increased the levels of observation from 3 to 4 levels, it includes clarity around the assessment of ETOC against these levels, better family involvement and the importance of escalation and requirement for accurate documentation where there are any concerns regarding patient safety including rationale for any actions taken. This guideline will be implemented across the organisation during May 2025 with a plan to evaluate the impact of this guideline after six months.

During the Inquest, you identified a concern that there is a risk that future deaths will occur unless action is taken. The matters of concern were:

1. Guidelines for Level 2 EICO were not complied with
2. There was a lack of escalation to the Matron or Site Manager
3. Had Mr Taylor received the Level 2 EICO, assistance could have been provided to him which may have prevented his fall

Following the internal investigation there has been significant learning identified which has been reflected within the actions as indicated above including clearer guidance for staff, importance of family involvement, escalation and documentation, training, and the use of professional judgement. In Mr Taylor's case, he was required to be in a side room due to testing positive for Clostridium Difficile. The allocation of a patient to a side room with infectious conditions is always a balance of risk between their individual needs and the protection of other patients in the open bay areas. The nursing staff responsible for his care did not feel, at that time, that he required EICO level 2 as he had become settled. Whilst we recognise the importance of professional judgement; given this is guidance and not policy; the staff failed to record their decision and the reasons for not escalating this further to the Matron or Site Manager.

Mr Taylor was assessed to have mental capacity on admission to hospital, however two days later he fell and the staff responsible for his care believed he then lacked capacity. They followed the trust policy by completing an MCA1 and 2 and a Deprivation of Liberty Safeguard, a safeguarding referral was then made to the Local Authority.

I would like to assure you that this improvement work is progressing well, and we intend to embed this ETOC guideline and will monitor the training achievements as they are introduced.

As you will note, the Trust is addressing the shortfalls highlighted during the Inquest to prevent future deaths in similar circumstances. Progress of the actions detailed in this letter will be overseen by Melanie Johnson, Executive Director of Nursing, Midwifery and Allied Health Professionals, who will also keep me briefed and report progress to the Trust's Patient Safety and Quality Committee.

I trust this information provides assurance to you that the Trust has taken appropriate action to address your concerns with a view to improving patient care and safety and reducing the risk of any similar adverse incidents in the future.

I would also like to take this opportunity to offer my sincere condolences to Mr Taylor's family on behalf of myself and the Trust.

Yours sincerely

[redacted]

Chief Executive