Northumbria Healthcare
NHS Foundation Trust

Patient Services and Quality Improvement

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6 May 2025

IN CONFIDENCE
Mr Andrew Hetherington
HM Senior Coroner for Northumberland
Coroners Court
County Hall
Morpeth
Northumberland
NE61 2EF

By email only: [redacted]

Dear Mr Hetherington

Re: Report to Prevent Future Deaths issued on 18 March 2025 – Inquest touching the death of Renate Mark

I am writing to you in response to the Report to Prevent Future Deaths (PFD) served on Northumbria Healthcare NHS Foundation Trust on 18 March 2025, regarding the death of Renate Mark. For ease of reference, I have addressed each concern in the same order as referred to in the Report.

Concern 1: The deceased was assessed as a level 3 falls risk meaning she was to be kept under line of sight in case of falling. Witness statements served in advance of the inquest stated the fall was witnessed. It was however eventually accepted in evidence that the fall was in fact unwitnessed. The precise circumstances of the fall could not be determined. All of the investigations undertaken by the Trust relied upon the incorrect understanding that the fall was witnessed, and observations were in line with Trust falls policy, when they were not.

The incident concerning Mrs Mark occurred on Ward 9 of the Northumbria Specialist Emergency Care Hospital (NSECH). As an immediate response, the Trust is in the process of briefing the ward team, which includes all clinical staff, on what constitutes a 'witnessed' and 'unwitnessed' fall and the importance of ensuring that this terminology is understood and used accurately, where an incident occurs. The briefing will explain the importance of ensuring accurate terminology is understood and used when information is disclosed to family following a falls incident, in order to allow for a robust internal Trust investigation and in circumstances

where a fall is witnessed or unwitnessed in the context of a subsequent Coroner referral or inquest that may follow. It is anticipated that this work will be completed by 31 May 2025.
In terms of a Trust wide response, the Trust's Strategic Falls Group advises on the strategic direction and actions that are to be taken by the Trust where there is a patient safety incident concerning a falls risk. As a direct response to the concerns raised by H M Coroner in the PFD Report, the group has been tasked with undertaking a review of the Trust's current Integrated Falls Prevention Policy and to provide further detail within the policy, including the inclusion of a glossary, citing definitions of wording contained in the policy, which is to include the definition of a 'witnessed' and 'unwitnessed' fall. The use of the term 'peripheral vision' will be removed from the policy and replaced by the wording 'in line of sight' so as to avoid any potential confusion by staff. The finalised policy will be agreed at governance level through the Trust's governance structure and thereafter will be included in the syllabus for future falls training sessions and events that are attended by all staff Trust wide, that are responsible for handling patients.
The revised Integrated Falls Prevention Policy will then be supported by a Trust wide communication strategy to ensure staff are aware of the revised policy, and the policy updates contained therein. The Policy updates will be shared Trust wide via the Trust Communications Bulletin, Heads of Department meetings, site meetings via team meetings and ward safety huddles, led by the ward Matron and also at governance meetings. In addition, the revised policy will continually be referred to in mandatory annual refresher falls training that is undertaken by all staff involved with handling patients. It is anticipated that this work will be completed by August 2025.

Concern 2: The inquest heard that it is practice within the Trust that a Nursing Assistant is to be located centrally in the corridor on Ward 9 to oversee patients assessed as at risk of falling and for the patients to be within staff's peripheral vision. The inquest heard that on 24 April 2024, 8 patients were assessed as level 3 falls risk and 1 patient was assessed as level 4 falls risk. I am concerned as to the number of patients at risk of falls being observed in this way. I am further concerned that there is a misunderstanding of what is meant by peripheral vision and what constitutes a witnessed or unwitnessed fall.

In relation to Mrs Mark's fall, the nursing assistant was assigned to Pod 3 on Ward 9; there were 8 patients being nursed in single bedrooms each with an ensuite bathroom. Pod 3 has a circular design which would enable a member of staff to observe those 8 rooms, through windows and glass/open doors from the corridor. At the time of the incident, patients were asleep/settled, and it was only Mrs Mark that was awake requiring the toilet. As she required the toilet and was at risk of falling, in order to maintain her safety, the nursing assistant should have called for additional support from another colleague to ensure falls observations for the other patients were maintained whilst he attended to Mrs Mark's in the bathroom. This learning has been fed back to the Ward 9 Team and nursing assistant involved in the incident. The importance of maintaining line of sight observation and calling for assistance when required will be further highlighted in staff training.

The Trust is confident that robust processes are in place to assess acuity of care at ward level for all wards as detailed in Claire Simpson's statement dated 13 March 2025 (served with the court as part of the inquest process). The processes are led by Matrons and supported by Operational Managers and Operational Leads, who are responsive to increasing staffing in order to address any concerns raised regarding increased patient acuity. There is also a process in place supported by funding, where staff can request additional staffing i.e. Bank staff, in order to support high numbers of patients at risk of falls. Bank staff are a Trust employed workforce, who provide cover on a pre booked, as needed basis. They are trained to Trust standards for falls management. As the number of patients assessed as requiring enhanced support and observation is fluid and will change throughout the course of the day, ward Matrons are tasked with attending the wards several times per day in order reassess acuity levels and to discuss management plans with ward teams where necessary.

Matron [redacted]'s statement previously referred to, also provides information in relation to staffing levels and patient acuity being monitored on an ongoing basis through the use of the Safe Care Tool, which is linked to the Allocate electronic roster system.

Whilst the Trust is assured that processes are in place to appropriately assess, escalate and respond to patient acuity, in response to this concern, the Trust does consider it prudent to remind all ward staff Trust wide of the importance of escalating concerns around staffing levels and/or workload pressures. Matrons will continue to formally discuss acuity levels with staff when they carry out safety rounds on the wards in order to encourage staff to discuss any concerns they may have. The safety rounds occur at each shift changeover and a minimum of 4 times every day; additional safety rounds take place where patient acuity is known to be high. H M Coroner's concern in relation to '*a misunderstanding of what is meant by peripheral vision and what constitutes a witnessed or unwitnessed fall'* has been addressed in response to concern 1 above.

Concern 3: I am concerned there is not greater scrutiny of witness accounts as part of the Trust's investigation process in particular given the concerns raised by the deceased's family early in the investigation and the other witness accounts to provide earlier learning to prevent future events.

In response to this concern, the Trust Governance Leads, who are trained in investigation management, will be involved in all internal investigations in order to ensure in depth scrutiny of witness accounts following an incident. Where any deficiencies or further information / clarification is needed, this will be fed back to the investigating officer to action. The Governance Leads will also ensure that the statements collated as part of the Trust investigation, are signed off at a Managerial/Deputy Director level adding an additional layer of scrutiny before final sign off.

This process will ensure timely, detailed and accurate witness statements are collated as part of the investigation and that they are dated, timed and signed by the witness, the Investigating Officer and the Manager/Deputy Director as being a true and accurate record of events. This in turn will allow for learning to be identified and implemented at an early stage in the investigation process.

In light of the above, we hope that you are assured that appropriate actions have been taken and will be taken in response to your concerns outlined in the PFD Report.

Please do not hesitate to contact me should you require any further information.

Yours faithfully

[redacted]

[redacted]
Chief Executive