Homerton Healthcare
NHS Foundation Trust

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Ms ME Hassell
HM Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

13 May 2025

Dear Madam,

Re: Regulation 28 Report to Prevent Future Deaths

I write in response to the Regulation 28 Report to Prevent Future Deaths dated 27 March 2025 issued to Homerton Healthcare NHS Foundation Trust ('the Trust') following the inquest touching the death of William David Patrick Hewes.

This response has been prepared with input from the Chief Nurse and various members of the Emergency Medicine and Intensive Care teams.

We express our sincere condolences to the family and loved ones of William. We take the concerns raised in the Regulation 28 Report seriously and are committed to taking appropriate action to prevent similar occurrences in the future.

In the report, you have raised the following:

1) William's life-threatening condition was recognised immediately he attended hospital, but he did not receive the necessary treatment as promptly as he should have done. The cause of the delay was multi factorial.

2) I heard at inquest that the Homerton University Hospital NHS Trust has done a great deal of work since William's death to try to avoid this sort of situation arising in the future.

3) If future patients at the Homerton can benefit from William's death, then why not future patients elsewhere? It seems to me that there would be great merit in sharing the learning nationally. Action should be taken to prevent future deaths

In order to share the learning nationally the Trust have taken and are proposing the following actions:

1) The Trust are one of the pilot sites for the first phase in implementing Martha's Rule. This is a major patient safety initiative providing patients and families with a way to seek an urgent review if they are concerned about a loved one's deterioration. Part of this first phase is to help the NHS to devise and agree a standardised approach to all three elements of Martha's Rule (ahead of scaling up to further sites in England in the following years). Once fully

implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a team skilled in managing deterioration if they are worried about a person's condition as well as being asked on a routine basis about how they are feeling. As part of the pilot programme, we are regularly meeting with other pilot sites and sharing the lessons learnt during the implementation of the programme. This learning, alongside our data, is being shared with NHS England to help inform nationwide implementation of Martha's Rule. This pilot is ongoing (started in May 2024).

2) One of our local actions was to deliver SIM (simulation) training to clinical staff. Simulation training is a tool used to gain practical experience, make informed decisions and refine their performance within controlled settings. The SIM training is focused on ensuring closed loop communication / direct instruction to team members when managing sepsis and shock in emergency situations. The plan is to develop this and deliver it on our Regional Trainee Teaching programme to resident doctors on managing human factors within healthcare. This course runs regularly throughout the year, we are aiming to incorporate the learning on closed loop communication into the next programme. The training runs 3 to 4 times a year.

3) Share the success of the RESPOND training programme at Regional and National conferences / meeting – the RESPOND programme provides training for nurses and nursing associates working in adult areas to support and develop knowledge and understanding in recognising early signs and need of the deteriorating patients including those with sepsis.

4) In agreement and in collaboration with William's family share "William's Story" at National and Regional Patient Safety meetings to support and promote learning on managing sepsis, recognition of deterioration and listening to families.

We hope that this information provides you with the appropriate assurance that we have taken these issues seriously and are determined to implement effective changes to prevent future deaths. We trust that the above actions and learning can be shared more widely to support improvements elsewhere. I would like to reiterate our sincere condolences to William's family and express our commitment to learning from this tragic event.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer and Place Based Leader