University Hospitals Plymouth NHS Trust

Chief Nurse & Director of Integrated Clinical Professions
Level 7, Derriford Hospital, Plymouth, Devon, PL6 8DH

Tel: [redacted]

2nd May 2025

Mr Nicholas Lane
HM Area Coroner
County of Devon and Plymouth and Torbay

Dear Mr Lane

Re: Mary Margaret Pomeroy deceased – Regulation 28 Prevention of Future Deaths Report

I write in response to your Regulation 28 Report dated 01 April 2025 concerning the sad death of Mrs Mary Margaret Pomeroy.

I would like to express our sincere condolences to Mrs Pomeroy's family.

We have reviewed the concerns you have raised in the report regarding the investigation into the circumstances surrounding the death of Mary Margaret Pomeroy, which was undertaken using the Serious Incident Framework, as was mandated by NHS England at the time of the incident.

In June 2024, in line with other NHS Organisations across England, University Hospitals Plymouth NHS Trust (UHP) transitioned to the use of the Patient Safety Incident Response Framework (PSIRF) and ceased the use of the Serious Incident Framework (SIF).

The principles set out in the Patient Safety Incident Response Framework have fundamentally shifted the approach to safety, and investigations into safety incidents within UHP. The PSIRF is not solely an investigation framework but instead looks to support and develop a culture of transparency and learning, supporting the development and maintenance of an effective patient safety incident response system. It incorporates x4 Key Elements:

1. Compassionate engagement and involvement of those affected by patient safety incidents (patients, families and staff)
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

In support of the above elements, the Trust has taken the following actions:

1. Creation of a patient communication handbook
    a. This is provided to patients and their families who are involved in safety incidents.
2. An information leaflet has been created for staff, outlining the purpose of the investigation, the process that will be followed and signposting to support option.
3. The ongoing development of a Just and Restorative culture has been added to the Terms of Reference for a Key Quality sub-committee (the Care Improvement Group)
    a. Research indicates that barriers to transparency included fear, blame and shame. A just and restorative culture is key to addressing this. By ensuring the ongoing development of such a culture is included in the Terms of Reference for the Care Improvement Group, two elements are achieved:

i. The delegated authority of the Safety, Quality, People and Culture Committee (a board sub-group) to the Care Improvement Group ensures that the group has the authority to undertake any actions as it deems necessary to promote a Just and Restorative Culture
ii. Regular update on progress in implementing this culture will be provided to the Safety, Quality, people and Culture Committee, ensuring regular, board level oversight

4. Recruitment to x2 Learning Response Lead posts.
    a. Both Learning Response Leads have completed mandatory training in compliance with national guidelines set out in the Patient Safety Incident Response Framework. Whilst not a requirement, both UHP Learning Response leads have backgrounds associated with the delivery of clinical care (as a paramedic and a biomedical scientist) with professional registration.
    b. These specialist investigators will undertake any Learning Response commissioned by the Patient Safety Incident Response Group. In addition, these individuals will provide specialist support and guidance in relation to other ongoing safety review processes (e.g. local Care Group investigations).
    c. The support of the Learning Response Leads will ensure that investigations within UHP move away from Root causes Analysis (which has been shown to be ineffective) and towards a model which supports understanding outcomes within complex socio-technical systems such as healthcare..
5. Recruitment of two Patient Safety Partners. The remit of the Patient Safety Partner role is set out in the National Patient Safety Strategy through the Framework for Involving Patients in Patient Safety. Patient Safety Partners are lay people, who have extensive experience of receiving care and on occasion, may have been involved in safety incidents. As such, they provide a different perspective on patient safety, removing the potential of influence by organisational bias or historical systems.
    a. The UHP Patient Safety Partners not only sit on key governance committees, but also support investigation processes through the ongoing review and challenge of the investigation process (during the investigation) and provide similar scrutiny to final reports.
6. Developed a new policy for the investigation of safety incidents, which includes new investigation methods
7. Redesigned our governance processes to further promote transparency and proactive multidisciplinary review of quality concerns and undertaking assurance work on any actions implemented as a result of those concerns. We have done this by ensuring:
    a. Where investigations are commissioned, the Terms of Reference are agreed through a multi-disciplinary approach and discussed with patients and families. As part of this process we would consider any previous similar incidents and ensure key leads (this may be medical or nursing leads, Allied Health Professionals, patient advocates, managerial support or any other key personnel involved in the delivery of patient care) are involved in the investigation processes.

The investigation process University Hospitals Plymouth NHS Trust now follows is undertaken in accordance with the Patient Safety Incident Response Plan and includes the following:

1. Patient safety incidents are recorded via a number of processes, including a healthcare safety incident, patient concerns raised through a complaint or PALs. Staff concerns can also be raised as per the NHS 'Freedom to Speak Up' policy. On the identification of a concern, a DATIX is raised.
2. The concern is then raised at the Patient Safety Incident Response Group ('PSIRG'), via a formal escalation report (this meeting is chaired by the Trust Patient Safety Specialist and attended by a multidisciplinary team that includes subject matter experts).
    a. Concerns can be raised through any source, including incidents reported to Datix, patients, staff, key external stakeholders, scrutiny of quality outputs or in response to key national reports and findings.
3. The PSIRG commissions a review as follows:

   a. There a number of different review options which are included in a separate file. The PSIRG will collectively decide the most appropriate response type.
   b. The terms of reference are agreed through a Multi-Disciplinary Discussion. These are discussed with patients and loved ones to ensure they encompass any concerns they have
   c. The review is assigned to a lead reviewer, who has the appropriate training and subject matter expertise to undertake
4. The review is undertaken using a range of system-based approaches to learning keeping family and loved ones involved as much as they wish.
5. A draft of the review is discussed at an "Open Door" event which is attended by a range of key stakeholders, ensuring that all perspectives of the incident are discussed.
   a. The draft is also shared with family and loved ones for their input.
   b. Recommendations for improvement are agreed with all key stakeholders
6. The review outcomes and process are presented to the Care Delivery Group, a meeting chaired by either the Head of Quality, Safety & Governance, or the Chief Nursing Officer and Chief Medical Officer as required..
   a. The Care Delivery Group (CDG) seeks assurance on the extent of the review process and considers the appropriateness of the findings and agrees the recommendations made. In relation to review outcomes, the CDG may:
      i. Be assured on the review process and outcomes, agreeing with and endorsing the recommendations
      ii. Challenge any part of the review process or outcome.
      iii. Commission further review where necessary (in cases where it is felt the review presented was not robust enough, or did not capture the correct recommendations)
   b. The recommendations are assigned to a key stakeholder to then develop specific actions to drive improvement.
   c. Assurances on the progress and implementation of recommendations is sought by the Care Improvement Group, which is chaired by the Head of Quality, Safety & Governance.

I do hope that this detailed explanation provides you with the assurance that you require but please do not hesitate to contact me if you should require any further information.

Yours sincerely

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Chief Nursing Officer and Director of Integrated Clinical Professions