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Private and Confidential
Mrs Wheeler
Assistant Coroner
The Guildhall
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Our Ref: PFD/LF

16 May 2025

Dear Mrs Wheeler

Mrs Linda Farmer: Regulation 28 Report

I am writing to provide assurance on the concerns that were raised following the Structured Judgement Review (SJR) and the failure of the trust to carry out a detailed investigation in relation to the concerns noted.

I would like to assure you that the trust takes seriously any circumstances that could lead to learning and improvement with any aspect of patient care and apologises that the appropriate review did not take place in this case.

Incident investigation has developed throughout the NHS with the implementation of the Patient Safety Incident Response Framework (PSIRF). The PSIRF framework involves a system-based approach to learning, considered and proportionate responses, and supportive oversight focussed on strengthening response systems and improvement.

The trust ensures that any reported incident is reviewed proportionately and where there are safety concerns identified, these are discussed at the weekly Incident Review Group (IRG) meeting to determine a proportionate response and share learning. The IRG is a multi-disciplinary team (MDT) meeting made up of senior Medical, Nursing and AHP staff.

The request for further investigation and the failure to do so in the case of Linda Farmer has been reviewed. The findings of this were, that whilst the need for further investigation was identified by the mortality team and discussed with the Patient Safety Team, the plans for this were not finalised. Regrettably, this did not progress, and the further investigation was not completed.

I would like to provide you with the assurance that since this case we have established a robust process in which all SJR outcomes are reviewed in a weekly MDT meeting, with

actions set that are tracked through to completion, and I am confident that this situation will not arise again.

I would also like to provide you with assurance that this case was brought for discussion in the Trust IRG meeting. The proportionate response that was determined by the group was that this case should be discussed in the directorate Mortality and Morbidity meeting, to identify any learning from the case. I can confirm that this happened on the 25 April 2025.

Yours sincerely

[redacted]

[redacted]
Medical Director