Our Ref: INQ/2425/069
Your Ref: 13567700

22 July 2025

PRIVATE AND CONFIDENTIAL
Margaret Taylor HM Assistant Coroner for Cumbria
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT
Tel: 0300 303 3180

Sent via email: hmcoroner@cumbria.gov.uk

Dear Ms Taylor,

Re: North Cumbria Integrated Care's Regulation 28 Response and Action Plan Concerning the Inquest into the death of Sarah Kathleen Hill

I write following the inquest held on 13th May 2025 into the death of Sarah Kathleen Hill. You concluded that Mrs Hill sadly died on 8th November 2024 at the Cumberland Infirmary in Carlisle, Cumbria. The medical cause of death was confirmed as:

1a Systemic Inflammatory Response Syndrome

1b Common bile duct perforation and Pancreatitis

1c Gallstones

II Coronary Artery Atherosclerosis

A conclusion was recorded that Mrs Hill died as a consequence of the recognised complications of a necessary medical procedure (an Endoscopic retrograde cholangiopancreatography (ERCP) to remove gallstones in her common bile duct).

During the inquest, the evidence revealed matters giving rise to concern, and you felt future deaths may arise if the Trust did not take action. Therefore, as is your statutory duty, you reported the matters of concern and issued a Regulation 28 to the Trust.

We acknowledge the findings of the inquest into the death of Mrs Sarah Kathleen Hill and thank you for highlighting areas of concern. We offer our sincere condolences to Mrs Hill's family.

The Trust takes safety issues very seriously and ensures that any concerns identified are addressed promptly to enhance our services and provide safe, effective care. Mrs Hill's case has led to a comprehensive internal review, and we are committed to implementing quality improvements to prevent future deaths under similar circumstances.

This document serves as a formal response to the concerns raised under Regulation 28, outlining our immediate and long-term actions. Enclosed is the Trust's corresponding action plan, which incorporates the identification and embedding of all learning relevant to Mrs Hill's case, whether identified by the Regulation 28 Report or not.

Concern 1: Inadequate Falls Risk Assessment and Incident Reporting
Response:
The Trust acknowledges the failure to evidence appropriate falls risk assessment and timely incident reporting in Mrs Hill's care.

A falls risk assessment (FRAMP) was completed upon admission to the Acute Medical Unit (AMU), with Mrs Hill assessed as mobile and independent. FRAMP assessments are required to be reviewed twice daily on every shift by the nursing team. Following her vasovagal collapse at approximately 12:00 hours on the morning of 7 November 2024, the FRAMP was appropriately updated later at 14:20 hours. This updated falls risk assessment did show that Mrs Hill was at risk of falls however there is no evidence that any falls controls were applied at this time such as ensuring the environment is clutter free, well lit, that a call bell is in reach, remind patients to wear glasses when mobilising or additional supervision mobilising.

At the time of the vasovagal collapse incident, it was categorised as a collapse rather than a fall, which led to confusion about whether an incident report was necessary. The clinical record documented that a doctor was called to review Mrs Hill in response to an emergency escalation call following her collapse. Mrs Hill had experienced an episode of dizziness while on the toilet after passing diarrhoea (without blood). Although her vital signs were stable and she was able to speak in full sentences, we recognise that clearer protocols for incident reporting and timely documentation were needed.

Mrs Hill had a further unwitnessed fall (or collapse) around 5pm (she had been moved to a single room at this time) shortly before she suffered a cardiac arrest. Again, this incident was not reported in line with our Trust policies.

In summary, the Trust had not documented the two episodes falls (or collapses) which occurred on 7 November 2024, even in retrospect. Although, there were evidence that FRAMP assessments were completed appropriately, there was no record of any mitigating actions taken from the repeat FRAMP assessment resulting in a new falls risk following Mrs Hills first collapse at 12:00 hours on 7 November 2024. It is noted that Mrs Hill did have her lying and standing blood pressure (BP) completed (as is the case for all patients on the Acute Medical Unit (AMU) in keeping with falls prevention best practice.

Actions Taken / Planned:

> **Immediate Assurance Check:** An urgent assurance check on falls documentation and current patient monitoring on AMU is being completed to confirm improved compliance post-incident. Additionally, the ward has an established programme of work to undertake thematic reviews of falls related incidents (including collapses) on a quarterly basis to determine quality improvement plans and identify any new themes that ought to be shared with other teams or added to our Falls Trust Wide Improvement Plan.
>
> **Compliance Review:** The trust is **r**eviewing the falls assurance evidence being captured by those wards undertaking Quality Accreditation to ensure that results are aligned with the Trust-wide Falls Improvement Plan and are linked to individual ward SMART improvement plans.

Protocol Update: The FRAMP policy will be revised to mandate reassessment following sedation, clinical deterioration, or medical procedures. This will include reinforcement of prompt documentation.

Incident Reporting Training: Refresher training is being delivered to all AMU nursing staff to clarify expectations around reporting collapses, falls, and unwitnessed incidents with an emphasis on always reporting even if there is doubt. Clarity will be included on borderline definitions and thresholds for reporting. This training will be expanded based upon the findings of the compliance review audit.

Concern 2: Incomplete Documentation of Cot Sides (bed rails) and Call Bell Placement
Response:
The Trust recognises that there was insufficient documentation of bed rails and call bell accessibility. On admission, Mrs Hill declined bed rails as she was independent. It is standard practice to use bed rails during patient transport for example, when Mrs Hill was transferred for have the computed tomography (CT) scan. However, in Mrs Hill's case, there were no documentation verifying whether the bed rails were to remain up upon her return to the ward given the earlier collapse and updated FRAMP. This documentation gap was of significant concern.

Actions Taken / Planned:

Electronic Documentation Enhancement: The Web V electronic record system is under review to explore the options to introduce mandatory (cannot be bypassed) fields for bed rails status and call bell placement. NB: WebV will be replaced as part of the implementation of a new electronic patient record in 2026 and this feature will be explored with the supplier to ensure any progress made with WebV is not lost.

Daily Spot Checks: The daily Nurse-in-Charge quality checklist will be revised to include specific items on bed rails, call bells and environmental safety.

Twice-Daily Environmental Review: Implementation of a formal twice-daily spot check at each handover by the Nurse in Charge will ensure accurate recording of safety measures.

Concern 3: Infrequent Observations despite Clinical Deterioration
Response:
The Trust acknowledges the concerns around vital signs monitoring and the lack of escalation of Mrs Hill's deterioration on 7 November 2024 which was not in line with the Trust's policies.

Following Mrs Hill's ERCP procedure on 5 November 2024, she was admitted to the AMU at 19:00 hours with a diagnosis of post-ERCP pancreatitis based on a significantly raised amylase level. Mrs Hill's condition initially appeared stable, with a planned 4-hourly National Early Warning Score (NEWS 2) in response to the score of 0-1 due to temperature 38.2°C on 6 November 2024. In line with the Trust policy (4-6 hourly observations for the first 48 hours unless NEWS2 triggers a change/escalation), the vital signs monitoring remained at 4 hourly.

On 7 November 2024, Mrs Hill's clinical condition deteriorated with rising NEWS scores (up to 4), a new onset atrial fibrillation, and increasing symptoms such as shortness of breath and rigors. This was initially escalated to the medical team who reviewed Mrs Hill at 09:55 hours on 7 November 2024; the observation frequency remained at 4-hourly intervals. At 11:48 hours, Mrs Hill experienced the suspected vasovagal episode. This episode was not escalated and Mrs Hill remained on 4 hourly observations which is in line with the Trust's NEWS policy.

Mrs Hill was moved to a single room due to infection suspicion. A CT scan confirmed severe complications, including intestinal perforation, necrotising pancreatitis, and possible aspiration pneumonia and at 16:00 hours a critical set of observations was missed.

Mrs Hill experienced an unwitnessed fall or collapse around 17:00 hours, and while being assessed, became unresponsive and went into cardiac arrest at 17:54 hours. Mrs Hill's vital signs during this period were unobtainable (the clinical team were unable to obtain her BP, heart rate or oxygen saturation; her temperature was 36.6°C).

In summary, it is clear that clinical observations were missed at 16:00 hours (should have been the 4hourly point) which is not in line with the Trust's NEWS2 policy. Mrs Hill's NEWS2 had been increasing earlier on 7 November 2024 and there did not appear to be an escalation to medical team. The Trust acknowledges that this may have been compounded by the move of location and change of nursing staff.

The Trust recognise there was no follow up and communication between AMU and the surgical procedure (endoscopy) team. The Endoscopist who treated Mrs Hill was unaware of her deterioration or death until nine days later. Currently, there is no established system for tracking, updating or follow up by Surgeons/Endoscopist, which presents a gap in continuity of care. This indicates an area for improvement ensuring in care continuity.

Actions Taken / Planned:

- **Early Warning Score (NEWS2) Protocol Review:** Escalation protocols are to be reviewed to ensure clarity, accessibility, and use by the full multidisciplinary team (MDT), especially for patients with persistently raised NEWS2.
- **Deteriorating Patient Dashboard:** Options are to be explored to enhance real-time flagging systems within the electronic health record, including escalation alerts visible to nurses and medical clinicians if observations fall below safe thresholds.
- **Education Programme:** A targeted training programme for AMU MDT staff and other key wards is to be facilitated for nursing and junior medical staff to focus on staff roles in managing deteriorating patients, including sepsis and pancreatitis, aimed at nursing and junior medical staff.
- **Endoscopy–Ward Handover:** The Trust will review communication pathways between procedural units (e.g. Endoscopy) and admitting wards and ensure there is a clear process for follow up and handover post procedure, notifying treating clinicians of significant patient deterioration or death post-procedure and ensuring continuity of care and learning.
- **Post procedure admission –** The Trust site and leadership teams are to review and consider the correct admission route for patient admission pathway for post procedure specific for ERCP.

Concern 4: Use of Side Rooms without Monitoring Adjustments
Response:
The Trust acknowledges that the decision to place Mrs Hill in a side room without enhanced observation resulted in reduced visibility at a critical time. Mrs Hill's earlier collapse had raised concerns about the risk of infection, as she had experienced three episodes of diarrhoea. As a result a decision was made to place Mrs Hill in an isolation room according to the Trust's Infection Prevention policy and for privacy and dignity. Unfortunately the staff did not adequately address the risk of the loss of visibility that came with the arrangement.

Actions Taken / Planned:

Side Room Risk Assessment: Working with the infection prevention team, using the hierarchy of risks alongside professional judgement, develop and implement a Trust wide documented risk-

benefit protocol for placing deteriorating patients in isolation and include discussion with the medical team caring for the patient.

Intentional Rounding: Where side room care is necessary, intentional rounding will be re-enforced at least hourly, and staff are reminded of this through visual prompts.

Concern 5: Staffing Levels and Escalation Response
Response:
The AMU have experienced nurse staffing difficulties with temporary escalation beds being open indefinitely. This has significantly impacted the ability to staff the ward in line with the recommended safe nurse staffing ratio of 1:6. This was acknowledged by the Trust in 2025 and an increased funded establishment was awarded in April 2025. The AMU is now ensuring that staffing levels are maintained at a minimum of six qualified nurses 24 hours per day to maintain a maximum nurse-to-patient ratio of 1:7.8 (nurse in charge plus 5 nurses for 39 patients). Furthermore, a new safe staffing establishment was approved in April 2025 for the ward, increasing staffing levels to eight qualified nurses during the day and seven at night. This will further improve the ratio to approximately 1:5.5, significantly enhancing patient safety and care continuity. Recruitment to fill the gap substantively is underway.

The Trust recognise that the ward staffing challenges, particularly with single-room layouts which can further impact patient safety as evidence in Mrs Hill's experience. The ward and collaborative leadership team have discussed restructuring the ward to improve nurse visibility and responsiveness.

Actions Taken / Planned:

Staffing Escalation SOP Review: The Trust's Safe Staffing Escalation SOP will be revised and implemented to ensure that unmet staffing thresholds trigger action within 30 minutes, including redeployment. This will include a review of nurse-to-patient ratios.

Ward Layout Improvements: A proposal to split the corridor where the single rooms are, into two zones with two registered nurses is being developed and will be piloted to improve nurse-patient ratios in this part of the ward.

Admissions Ward Staffing Enhancement: The AMU will recruit into the new funded establishment to eight qualified nurses during the day and seven at night. Recruitment to fill the gaps substantively has been completed with new staff joining the AMU team over the next 2 months.

Cohort Monitoring: A pilot of a cohort-based care model for patients on the admission ward with elevated NEW2 scores is under development and if successful will be rolled out to other acute admission wards. This will allow greater visibility of patient's with a dedicated nurse for the area/room. Prioritise use of rooms 1-6 which are closer to the front of the ward and doctor hub room.

Additional Assurance
The case has highlighted the importance of addressing patient or family perceptions of care. The AMU team will work to include reflection on our communication style, staff approach, and the integration of kindness and attentiveness into our team training and values. This will be measured through existing friends and family surveys and our resulting improvement work.

The Trust is committed to learning from the tragic events surrounding Mrs Hill's death and ensuring that her case leads to measurable improvements in patient safety, clinical

responsiveness, and ward management. All actions are being overseen by the Trust's Patient Safety Group, reporting to the Executive Board of Directors and the North East and North Cumbria Integrated Care Board. A formal follow-up report will be provided to the Coroner by 28 November 2025 to outline progress made in the implementation of the above actions.

Yours sincerely,

[redacted]

[redacted]

Chief Executive Officer
North Cumbria Integrated Care NHS Foundation Trust