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Our reference: INQ497

Your reference: NJM/cb/tji/28304436

12 August 2025

Dear Mr Tait,

Inquest touching the Death of Hazel Gambles – Regulation 28 Response

I write further to your letter dated 17 June 2025, where you set out matters of sufficient concern to you to invoke your statutory duty under paragraph 7, schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

I was very sorry to hear that you were in a position where you felt a report was necessary. As a Trust, we take any deaths very seriously and always strive to learn from any incidents. I am very sorry to the family and friends of Mrs Gambles that our care didn't reach the expected standard and that they did not have the experience that we strive to achieve at The Rotherham NHS Foundation Trust.

For ease of reference, I have addressed your concerns in the order presented.

1. Lying and standing Blood Pressure was not recorded on admission.

In Mrs Gambles' care records it was documented that she hadn't had her lying and standing blood pressure taken.

Lying and standing blood pressure is part of the falls risk assessment and should be completed each time the risk assessment is re-done. To mitigate the risk of this being missed, there is now a falls champion on each ward and part of their responsibility is to educate the team around the importance of risk assessments. The falls champions are also tasked with completing checks to ensure that lying and standing blood pressures have been completed for those who need it.

There is also now a healthcare assistant assigned on every shift and part of their role is to ensure that those patients who require a lying and standing blood pressure, have had this undertaken.

Since Mrs Gambles' admission, the Trust has also implemented a nurse in charge checklist and a standardised nursing handover. The nurse in charge checklist provides a further level of senior oversight on the ward to ensure that risk assessments are being completed to the expected standard. Please find the nurse in charge checklist attached to this response as **Exhibit 1.**

2. There was no documentation of any falls prevention measures at the time of the first falls assessment.

In the care of Mrs Gambles, unfortunately there was no documentation to confirm whether any falls equipment was in place, following her falls risk assessment.

At the time of Mrs Gambles' admission, the falls prevention measures part of the risk assessment was not a mandatory field and so there was a risk that this would be missed. Since Mrs Gambles' death, this has now been changed to a mandatory field within the risk assessment. This means that nursing staff are unable to progress with documentation until they have completed the entry, and so it should be clear as to what falls prevention measures are required for each individual patient. Compliance with this is audited as part of the Tendable audit. The Tendable falls inspection overall outcome from February 2025 to August 2025 shows that overall compliance has risen from 78% in February 2025 to 98% in August 2025.

In relation to falls, the Trust has also successfully recruited a falls lead practitioner. This practitioner is due to commence next month (September 2025). The falls lead will have a responsibility to drive improvements in the prevention and treatment of all falls within the Trust. Part of their role will be looking at clinical effectiveness and to look at anything which may fall outside of the falls audit. They will also be reviewing the national falls audit and considering where further improvements need to be made.

The Trust has also now implemented a standardised safety huddle log. Please find this attached at **Exhibit 2.** Within this, there is a section in relation to falls and specific prompts to ask:

- Is the right equipment in place and are falls prevention measures in place?
- Have the assessments been completed within the required timeframe?

The Trust will measure compliance and effectiveness of this throughout the implementation phase.

3. There is no evidence of falls prevention measures being put in place following the first falls assessment

As mentioned in the previous section, we have now ensured that these fields are mandatory and so this should prompt the staff to ensure that falls prevention measures are put in place.

The Tendable audit questions are monitored on a monthly basis and any actions arising from non-compliance with this are monitored. There is also a falls section

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within the Trust's Exemplar Accreditation programme which is designed around the CQC key lines of enquiry to ensure the quality of care delivered to patients within a ward environment. Each area is measured continuously.

It is also expected that once the falls lead practitioner starts in September 2025, part of their portfolio will be to ensure that appropriate audits take place and if there are any areas where further quality improvement work can be undertaken, they will be tasked with identifying this.

There are also monthly external assurance audits undertaken by someone external to the ward. A senior member of staff will go and look at the entire environment to see whether the appropriate signage is up – i.e. gingerbread man. The senior member of staff will also check on other aspects of the patients care such as nutrition and hydration documentation to ensure that everything is being undertaken as expected.

Each nurse also has a professional responsibility to make sure whatever they document is correct and implemented.

4. There was no falls assessment done at the time of transfer to ward B4. There should have been a falls assessment within six hours of transfer but that did not happen. The assessment took place some 23 hours after admission to the ward, by which time Mrs Gambles had already fallen.

Since Mrs Gambles' admission, we have now implemented an overview dashboard within the Meditech system (the Trust's medical records system). This is an electronic dashboard and shows in real time which risks assessments have been completed and which are still outstanding for each patient. The use of this board throughout the nurse in charge shift means that they now direct staff when assessments haven't been completed and it is much clearer to identify when risk assessments are overdue or have not taken place.

Risk assessments also now refresh on transfer to a new ward so that there is less risk of a staff member copying the previous ward assessments. On transfer to a new ward, the staff member will be presented will a completely blank risk assessment which will prompt them to fill in the assessment from scratch based on the patient's current presentation.

Ward B4 was initially set up as a winter pressures ward, but now has a substantive leadership team. As it is a new ward, it is in its baseline data gathering year and has not had an initial accreditation (using the Exemplar Accreditation Programme), however this will happen in October 2025 once there is a year's worth of data. This will include handover and falls assessments and any non-compliance will lead to clear improvement actions.

5. Following the in-patient fall there was a delay of over 5 hours before a medical review took place. The note recording the request for medical review is not timed.

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The induction of resident doctors includes sessions on resuscitation and more details are now included on the response to a deteriorating patient. The clinical teams (resident doctors and the acute response team) will prioritize deteriorating patients who need to be reviewed overnight (elevated NEWS2 scores or abnormal neurological signs). The Trust is moving towards employing two medical registrars on call overnight.

We have reviewed the national audit of inpatient falls (NAIF) data which demonstrates that the Trust is routinely completing accurate assessments for patients who fell in hospital and sustained an injury. The data confirm that the medical review for these patients is now taking place within 30 minutes.

Mrs Gambles' care will not be included in the NAIF figures as the inclusion criteria at that time only covered patients who had a fall that resulted in a fractured neck of femur. Since 1 January 2025, the audit now includes more injuries than just a fractured neck of femur. The audit now includes head injury, spinal injury, hip fracture, vertebral fracture, rib fracture, humeral fracture, distal forearm fracture, pelvic ring fracture or any other fracture.
As part of this audit, any patients who have had an inpatient fall that sustain an injury included within the audit, will be reviewed and the data shared, including improvement actions.

6. There was no discussion with Mrs Gambles' family explaining the findings of the CT scan and they were not told about the bleed on the brain.

Mrs Gambles' family should have been updated on the findings of the CT scan and I am very sorry to see that this didn't happen. To improve communication with family, we have implemented a number of changes.

There are daily ward rounds on all medical wards and the Trust is working to ensure that "board rounds" take place prior to the ward round to ensure that all relevant information is captured and that all patients have a senior review on a daily basis. Some consultants already have time in their job plans for a consultant communication with families after the ward round, via telephone call. We are now changing job plans to ensure that all medical consultants have dedicated time to do this.

The nurse in charge checklist includes a specific question to ask "is there any family meetings / communication needing to be arranged". The nurse in charge checklist is completed at each nurse in charge handover. The safety huddle log also includes a prompt to as "is there any family discussions that need to take place? Including changes in patient's condition, post incident, discharge planning." The safety huddle is completed three times a day (morning, afternoon and night).

As a Trust, we also now have a further safety net with the introduction of Martha's Law, which was introduced in February 2025. This provides a direct number for patients and families that feel they are worried about the medical care they are

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receiving, their condition is deteriorating, and they don't feel listened to or if they want a second opinion. The contact number is displayed across the Trust and within each Ward and Bay area. As a Trust, we have seen positive outcomes from patient and family feedback who have felt the need to access this resource and support.

7. No Datix report was done following the in-patient fall leading to a delay in investigation.

No Datix report was completed after the in-patient fall and this should have been done at the earliest opportunity, following the fall. The responsibility of completing a Datix report is the person who has identified a safety incident or significant concern. In the event that a Datix is not completed during the shift due to distraction, capacity or not having access to the system, this should be escalated to the nurse in charge who will complete on the persons behalf.

The nurse in charge checklist now asks the question “has there been any incidents? Have these been recorded via Datix?”. This gives an opportunity for the senior team to consider whether there are any outstanding incident reports and if so, ensure that these are reported at the earliest opportunity.

The induction for temporary staff form includes a specific section on Datix and when an incident should be reported and the process to follow post falls. Whilst the nurse involved in Mrs Gambles care wasn’t temporary, this ensures that any temporary staff on the ward are aware of the expected process to follow.

8. The in-patient fall is not mentioned on the Discharge letter.

The Trust acknowledges that the discharge letter was not to the standard that would have been expected and that crucial information, including the inpatient fall was not included within this.

As a Trust, we have now added a mandatory question to the inpatient discharge summary to ask whether the patient has had a fall, VTE (Venous Thromboembolism), pressure ulcer or any other incident. This will prompt clinicians to consider whether any of these have occurred and if so, it will be clear on the discharge summary. This will be monitored throughout the implementation stage, to ensure effectiveness.

We also review where we stand nationally in relation to falls and use a PowerBi dashboard to monitor this. I have enclosed the most updated version with my response at **Exhibit 3.** This demonstrates that although there has been a couple of months falls have slightly increased, we have predominantly been sitting under the national average for all falls and for moderate and above harms falls for quite some time.

I hope the above provides you and Mrs Gambles’ family with assurance that the Trust has taken this report very seriously, and has established stronger procedures to ensure that we improve the quality of care we provide to our patients.

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If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

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Chief Executive

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