Committed To Excellence | Working Together | Facing The Future

NHS
Frimley Health
NHS Foundation Trust

Frimley Park Hospital
Portsmouth Road
Frimley
Surrey
GU16 7UJ
0300 614 5000
www.frimleyhealth.nhs.uk

1st September 2025

HM Coroner Mr Robert Simpson
Assistant Coroner for Berkshire
Berkshire Coroners' Office
Reading Town Hall
Blagrave Street
Reading
RG1 1QH

Dear Mr Simpson

REF: YOUR REGULATION 28 REPORT TO PREVENT FUTURE DEATHS DATED 07 JULY 2025

I write further and in response to the Regulation 28 Report received on 07 July 2025, following the sad death of Mr Patrick Coffey on 29 September 2024. My deepest sympathies go out to Mr Coffey's family and those who knew him.

I am grateful for your thorough inquest into Mr Coffey's death. I would like to take this opportunity to reassure you that patient safety is taken very seriously by the Trust, and the Trust is committed to review and reflect on current practices to identify areas of improvement. I have carefully considered your observations, and the recommendations raised in your Regulation 28 Report to ensure that patients receive the best quality care at the Trust and that future deaths are prevented.

Matter of Concern 1: Repositioning Protocols

The Trust has an established Pressure Injury Reduction improvement work stream which is being led by the Corporate Head of Nursing as the Senior Responsible Officer which includes the clinical importance of repositioning for patients at risk of respiratory compromise and pressure injury. At the time of Mr Coffey's admission, repositioning protocols were supported by Waterlow assessments and physiotherapy documentation including repositioning records as part of the daily care plans within the Electronic Patient Record.

The improvement work stream is focussing on implementing a number of changes which will improve care and documentation across the Trust relating to repositioning and the prevention of pressure damage including the following:

- From 1 September 2025, the National Pressure Injury Screening Tool, Purpose T, will be implemented across adult inpatient and emergency departments, with maternity and paediatrics to follow later in December 2025. Through this period of change, the Trust will adopt the nationally recommended ulcer categories and care pathways, alongside a review of data validation processes. The Nursing, Midwifery and Therapies Board, will be monitoring the progress and the governance processes with escalation through established documentation and digital safety groups, and in due course a Trust-wide audit will be planned, with re-auditing scheduled to provide internal assurance.
- While Purpose T recommends repositioning, it does not prompt it directly. Accordingly, we have worked with our electronic patient record ("EPR") supplier EPIC to introduce task prompts at defined intervals, visible on the care plan interface to support compliance (as below). This work forms part of a broader pressure ulcer improvement programme aligned with the National Wound Care Strategy.
- This Pressure Ulcer Improvement Programme is recognised as part of the Trust's Patient Safety Incident Response Framework ("PSIRF") Plan and is a Trust Quality Improvement Priority for 2025–26.
- Awareness will be further supported through participation in national initiatives such as Stop the Pressure Week in November 2025.

The improvement work stream has been monitoring data as part of its Quality Improvement Methodology and for Quarter 1 2025/26 performance has significantly improved particularly for Category 2 pressure injuries with a 52% reduction compared to the same quarter last year.

<u>Matter of Concern 2: Staff Training and Awareness</u>

To support clinical teams, we have introduced system-driven prompts within the EPR that will automatically trigger repositioning tasks when patient pathways are documented. These appear on the care plan interface to ensure integration into routine workflows. For clarity, this prompt will not be recorded in the printed patient records, rather it will appear as an alert on screen for staff to take action. These prompts will be auditable on a ward and patient level, with staff able to pull through repositioning information onto a dashboard for reporting and auditing purposes.

The Trust has also launched a targeted staff communication campaign, including the distribution of an EPR Bulletin to all relevant clinical teams, these are regularly shared to highlight key educational messages to staff. I understand that the Bulletin reinforcing the importance of timely and accurate documentation of patient repositioning was shared with your office in early July. To further support staff, the Trust has expanded our Digital Ambassadors Network, providing peer-to-peer training and access to 'training buddies' who can assist with EPR-related queries and reinforce best practice.

Education sessions have also been delivered, and in addition the Trust Clinical Education and Practice Development Teams have been visited wards to support staff in practice with documentation of repositioning, risk assessments and using EPIC effectively.

A formal Harm Free Care Audit Programme is in place (commenced July 2025). The pressure injury prevention sections tests out whether assessments have been done in a timely manner and whether the appropriate care interventions such as repositioning have been put in place. The audit in July 25 showed a 20% improvement in the documentation of the interventions from a previous audit (60% to 80%) compliance.

Matter of Concern 3: Electronic Patient Record

Your concern about the clarity and completeness of EPRs, particularly in relation to the documentation of patient repositioning, has been noted. We recognise the importance of ensuring that clinical records are both accurate and accessible, especially when reviewed in the context of coronial investigations. The Trust acknowledges that the version of the records disclosed to the Court differ in appearance from the user-interface that staff access, which can be challenging at inquests.

To address this, the Trust is working directly with EPIC National Team to review the current output documents provided to Coroners. The objective of this review is to enhance the clarity, structure, and usability of these records, ensuring they support the coroner's review process effectively. In parallel, we are engaging in a collaborative learning initiative with the wider EPIC user network to understand common challenges in presenting electronic clinical notes 'off system' and identifying best practices to be adopted locally. Further, the Trust remain open to meet with the Senior Coroner for Berkshire to discuss this matter further.

I hope that my response highlights the steps that the Trust has and will continue to take to improve the patient safety at the Trust, in particular repositioning which falls under the Pressure Injury Reduction improvement work stream. An improvement plan based on learning from this inquest, to include the actions above, will be created and actioned with monitoring by the appropriate clinical governance teams within the Trust.

The Trust appreciates your thorough investigation and challenge, both of which are essential so that the Trust can continue to learn lessons and take steps to improve patient safety and the quality of care we provide our patients. As ever, my thoughts remain with Mr Coffey's family and all those affected by his very sad death.

Yours sincerely

[redacted]

[redacted]

Chief Executive