University Hospitals Birmingham
NHS Foundation Trust

Queen Elizabeth Hospital Birmingham
Mindelsohn Way
Edgbaston
Birmingham B15 2GW

[redacted]

7th October 2025

For the attention of Mrs Louise Hunt
Senior Coroner for Birmingham and Solihull

[redacted]

Dear Mrs Hunt

Inquest touching the death of Robert Simpson
Response to Regulation 28 Report to prevent future deaths

I am writing in response to the Regulation 28 notice issued following the conclusion of the Inquest on 7 August 2025 touching the death of Mr Simpson who died on 9 July 2024 at Heartland Hospital (part of University Hospitals Birmingham NHS Foundation Trust (UHB)).

We have carefully considered the concerns raised within your report to prevent future deaths and would respond as follows.

1. It was accepted by the Trust that the deceased had been provided and discharged with medication (gabapentin) that did not belong to him and had missed two doses of antibiotics (fidaxomicin) due to the drug being out of stock, which had not been communicated to or escalated to treating clinicians.

The Trust does not dispute this and confirms, following the Trust patient safety investigation, that the deceased was discharged with the medication belonging to another patient and that two doses of antibiotics were not administered which had not been communicated or escalated to the relevant clinicians.

2. In evidence the Trust were unable to confirm whether the issues set out in 1. above sat solely with the nursing team or also involved pharmacy.

As per the Medicines Code, nursing staff are expected to appropriately record patient's own controlled drugs, conduct daily reconciliation as part of stock balance checks. This would have ensured that the medication (gabapentin) and its location were accounted for and would have prompted timely disposal if it was not suitable to be returned to the patient to whom it belonged, and this is where the deviation occurred.

The patient safety investigation identified that Trust medicines processes and procedures were not followed by nursing professionals on this occasion. Specifically, the registered nurses (RN's) involved in the admission and discharge processes for both Mr Simpson and the previous patient did not comply with the requirements of the Trust Medicines Code or the patient safety checking processes set out in the Medicines Management 'Fit for Discharge' checklist.

There are no actions UHB Pharmacy could have taken to prevent either of the missed doses as the incidents occurred out of normal working hours, and the drug was available in the emergency drug cupboard and dispensed directly to the ward. The expected standard for any omission of prescribed medication is that the omission is immediately escalated to the nurse in charge of the shift as per policy and procedure (medicine code).

At University Hospitals Birmingham NHS Foundation Trust, each hospital operates a system (Omnicell®) giving access to an emergency medicine cupboard which contains important medicines (but not Controlled Drugs), that may be needed when the Pharmacy is closed. Access to the cupboard is through the appropriate senior nurse on duty for the site. The practice of obtaining medicines from the emergency drug cupboards or other wards/departments applies to both ward stock and non-stock items and can take place at any time of day to facilitate urgent doses of critical medicines. Urgent critical medicines are supplied to requesting wards to avoid missed doses. The drug stock locator function on PICS or Pharmacy intranet page must be used to determine other areas that stock the medication required. The clinical site practitioner (nurse) must obtain supplies from the emergency drug cupboard / out of hours medicines cupboard. Where the medicine is not available within the emergency drug cupboard / out of hours medicines cupboard or as stock in another clinical area, the clinical site practitioner will permit the ward to contact the on-call pharmacist for advice and/or supply. In both missed dose incidents, appropriate Trust medicines processes were followed to access and obtain Fidaxomicin. The missed doses occurred due to nursing staff failing to record and communicate where the Fidaxomicin was being safely stored on the ward.

3. Whilst evidence was given in relation to the discharge nurse having undertaken reflection and a focus group being set up to explore improvements with discharge and planning there was no evidence as to how the wrong medication was provided to the deceased and whether this was a discharge only issue or also an issue with allocation and distribution of medication by pharmacy or by ward staff.

The incident investigation identified that the supply error arose because a previous patient occupying the same bedspace had been issued with a hospital supply of gabapentin on discharge. That patient's pre-admission (community-supplied) gabapentin remained in the secure bedside locker between 4-28 June 2024 and was not removed by the registered nurse who discharged the patient, prior to Mr Simpson being admitted to the bedspace. At the time of Mr Simpson's discharge, this medication was removed from the locker and, due to inadequate checks by the discharging registered nurse, was mistakenly 'returned' to him as if it were his own or part of his prescribed discharge supply.

This 'Fit to Discharge' checklist clearly sets out the steps required to ensure the safe reconciliation of medicines at the point of discharge. It involves verifying the patient's discharge letter or medication list and removing any inpatient medication and/or patient's own medicines that are not required for discharge from the bedside secure patient locker.

A spot check bedside locker audit was undertaken following the incident which further identified ten medications that had not been sent home with patients upon discharge. Each medicine's breach has been reported and investigated to ensure all patients have been provided with a sufficient supply of medications and that these medications were correctly labelled for the appropriate patient and verified against both the discharge letter and the list of medicines on the electronic prescribing and medicines administration system (PICs).

4. There was no evidence to explain how the deceased missed two doses of antibiotics due to the drug being out of stock, why treating clinicians were not informed or why an alternative antibiotic was not administered in its place. The Trust were unable to talk to what, if any, systems were in place to ensure that patients were not left without necessary medication.

Fidaxomicin was available either on the ward, in main pharmacy or within the emergency drug cupboard at Solihull Hospital throughout Mr Simpson's admission and was accessed as per the medicines code. On the 16 June 2024, the drug was in the bedside secure locker however nursing handovers had failed to communicate and/or document on PICs noting, where the medication was being securely stored and the RNs were not routinely checking the bedside lockers before administrations. In the event a registered nurse cannot locate a drug dose, then the emergency drug cupboard should be utilised. Fidaxomicin has low usage as it is a restricted antibiotic used as a second line treatment for clostridium difficile or on the recommendation of a microbiologist. Fidaxomicin is a high-cost medication (£1,600 for a box) and is therefore not recommended as a stock drug on any location across UHB clinical areas. However, it is available in all emergency drug cupboards, 24/7, across all UHB hospital sites.

Mr Simpson was diagnosed with clostridium difficile from a stool specimen taken on 13 June 2024 and a 10-day course of Fidaxomicin was advised by a Consultant Microbiologist, which was the prescribed by the treating team. A noting was added to PICS (EPMA Electronic Prescribing and Medicines Administration system) on 15 June 2024 at 18:50 by a registered nurse '*Fidaxomicin not in stock ordered from pharmacy for tomorrow (16 June 2024) but also informed first on (Clinical Site Practitioner) to get from emergency cupboard for tonight. Will handover to night staff to chase'*. Fidaxomicin is not kept as stock item on any ward at UHB so was obtained from the hospital emergency cupboard by a clinical site lead at 19:57. The first dose was prescribed at 18:46 and administered at 20:16.

First missed dose

On 16 June 2024, the 07:00 prescribed dose was not given by a registered nurse, and reason was recorded on PICs as 'drug out of stock'. At 11:37 a pharmacy technician spoke to a ward staff member and confirmed the ward had the Fidaxomicin as 20 tablets were checked out from the emergency cupboard the day before (15 June 2024) to the ward, therefore, stock was available on the ward at the time the dose was missed. At 12:02 the registered nurse located the Fidaxomicin and confirmed it was being stored in the patient's bedside secure medication locker. There was no documented reason on PICs as to why the registered nurse did not immediately administer the missed dose from 07:00 once the Fidaxomicin had been located and the nurse did not discuss omitting the dose with the nurse in charge or escalate to medical staff. The dose was not given until the next prescribed dose at 17:00, administered by different registered nurse.

Second missed dose

On 19 June 2024 Fidaxomicin was prescribed to be given at 17:00 but not administered by the registered nurse with reason recorded on PIC's 'drug out of stock'. There is no further documentation regarding omission actions or escalation to medical colleagues, the nurse in charge or pharmacy staff by the registered nurse. On 20 June 2024, pharmacy issued an additional supply of 12 tablets, following an order placed the previous evening by an RN (19 June 2024), when the dose was missed, to supplement the 13 tablets already available on the ward and ensure completion of the prescribed course. The omission was identified retrospectively by the senior infection control nurse (IPCN) on 24 June 2024 at 13:39. The IPCN noted on PICs there had been 2 missed doses and escalated to the nurse in charge a recommendation that the prescription be reviewed as 1 day of treatment course had been omitted. This was actioned and the prescription was amended by a resident doctor on 24 June 2024 to extend the treatment course to 27 June 2024. Based on the administration record, there should have been 13 tablets remaining in the bedside locker at that time, sufficient to administer the required doses.

Every administration was being completed by a different registered nurse so there was no continuity of care in terms of medication administrations and communication of where the drug was being securely stored. Whilst nursing staff through the course of their actions and checks, appear to have concluded that the antibiotic was not available, stock was in fact present on the ward following its removal from the emergency cupboard. It was nevertheless recorded as 'out of stock'. After the first missed dose, the medication was transferred to the patient's bedside locker, which should have prevented the second missed dose, as sufficient stock (13 tablets) should have been available. This suggests the bedside locker was never checked prior to omitting doses.

Every effort should be made to administer prescribed medicines as omission of certain medicines, or a delay in dosing, can be detrimental to a patient's well-being. Medicines identified within the Trust as "time-critical" medicines should never be delayed or omitted, unless clinically contraindicated or the patient refuses medication. Any omission, refusal or delay in the administration of time-critical medications must be discussed with the prescriber or relevant Physician and documented within the patient records. A medicine that has been omitted or refused on two consecutive occasions must be brought to the attention of an appropriate prescriber and the omission/refusal documented in the patient's records. Where the omission/refusal of a single dose is considered to be clinically significant e.g. medicines on the critical list, this escalation must occur immediately. If in doubt, the registered professional must discuss with the prescriber or relevant physician.

5. The coroner is concerned that there may still be a risk to life of patients within the trust if they are provided with the wrong medication or miss necessary doses of prescribed medication.

These medicines omissions have been retrospectively reported on the Trust RADAR incidents system and immediate actions have been taken to address the procedural failings with the individual responsible nurses. The patient safety incident and learning have been shared across surgical and medical inpatient clinical teams. To strengthen awareness, a Trust patient safety notice will be circulated to reinforce the process for obtaining time-critical medicines both in and outside of normal working hours, to reduce the risk of missed administrations across the organisation. The notice will be shared in department Safety Huddles, Ward team meetings, Newsletters, Clinical Assurance and Care Quality meetings. Induction training materials for healthcare professionals involved in medicines administration will be strengthened to emphasise the management of missed doses of time-critical medicines, including the requirement to escalate to the medical team where a dose is likely to be missed or has been omitted. The Trust Medicines Management Moodle training package is also under review, so will strengthen any sections on missed doses/time critical medications for all clinical substantive professionals.

Compliance is monitored in real time on the Trust Clinical Dashboard which shows the ward performance against the Trusts overall compliance. Data can be drilled down to see the individual drug omissions. Standards are clearly described in the Clinical Dashboard help section. Ward leaders/managers have individual processes to monitor these weekly. Key Performance Indicator (KPI) compliance is reported at Hospital Site level (Clinical Assurance, Care Quality and Quality and Safety Meetings) and at Group level (Group Care Quality Meeting). The monthly Group Clinical Dashboard Review Group (chaired by the Deputy Chief Nurse) reviews dashboard indicators and engages with wards that are both showing higher levels of omissions and lower levels of omissions to review their individual data and developed improvements which are then shared Trust wide to continually improve patient safety and quality of care.

Day to day compliance is supported by the PICS system which defaults to the drug chart when a registered nurse first enters the patients record. This was developed to ensure clear immediate identification of any missed medication. The Matrons and Ward/Unit leaders are responsible for overseeing, auditing and reporting audit outcomes and compliance through monthly Hospital Clinical Assurance and Care Quality meetings. These meetings are chaired by the Hospital Director and Associate Directors of Nursing. When areas are identified as not adhering to medicine standards and/or KPI’s, corrective actions and improvement plans are agreed, monitored and compliance reported through the Hospital and Trust Group Care Quality Meetings.

Compliance with the Medicines Code is audited by the following methods:

- RADAR records reported to each Safe Medication Practice Group meeting
- Missed Dose audits – every 6 months
- Controlled Drug audits in clinical areas – every 3 months
- Controlled Drug stock checking audits by clinical areas- monthly
- Safe Handling and Storage audits in Clinical Areas bi-annually

Medicines must only be administered to patients by registered practitioners or any healthcare staff who have been assessed as competent in the administration of medicines. Whilst all registered staff within the inpatient wards have completed and been signed off as competent in the management and administration of medicines, as a result of these incidents, all registered nurses within the Trust who are involved in the administration of medicines, are being provided additional training and education to refresh their knowledge, understanding and accountability relevant to their duties in drug administration in accordance with the Trust Medicines Code. Clinical Practice Educators within the School of Nursing are in the process of preparing a Medicine Management Webinar which will be provided to the Ward Leaders and Matrons across the Trust. The leaders and managers of each clinical area will be responsible for ensuring that the webinar is accessed by registered nurses as part of their essential training updates. The Matrons are responsible for ensuring that wards have the 'Fit for Discharge' checklist readily accessible within clinical areas, including at bed spaces and near patient medication lockers, where the discharge process is undertaken. This is to ensure that practice standards are consistently followed and adhered to.

Registered practitioners are expected to practice in accordance with the standards set in the UHB medicines code, and by their relevant UK professional bodies. They must also acknowledge any limitations in their knowledge, skills or competence to administer or check medicines. When the medication error was reported retrospectively through a formal complaints process by Mr Simpsons daughter, the Matron and Ward Manager initiated an investigation. A retrospective medication incident form was completed and associated practice improvement plan was developed at Solihull Hospital. To ensure that the findings, actions and learning from these incidents are shared widely, the improvement plan mandates inclusion of all clinical areas, across the hospital and community sites. In addition, ongoing monitoring of these practices will be conducted through the hospital Quality and Safety Governance agenda.

The registered nurses involved in the medication breaches have been individually counselled in accordance with the Trust's Standards for Management of Medication Administration Errors. This counselling addresses their practice and non-adherence to established processes and procedures, ensuring staff fully understand their role, clinical responsibility and accountability when administering and dispensing discharge medications to patients.

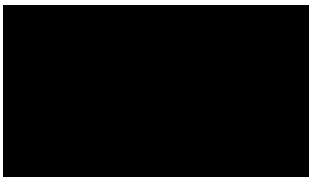
Matrons and ward managers at Solihull Hospital are also undertaking spot check assessments of registered nurses' practices when discharging patients from the medical and surgical wards. Outcomes and learning opportunities will be shared and discussed within the Clinical Assurance monthly group meetings with nurse leaders and managers. There have been no further reports of patients being discharged with incorrect medications, CDs not belonging to patients or medications belonging to another patient since this incident was raised at Solihull. The incidents have demonstrated several patient safety risks associated with the storage, handling and checking of medicines within clinical areas across Solihull Hospital. The safe and secure and handling of medicines (SaSHM) is audited bi-annually by the pharmacy department across the Trust. Compliance against SaSHM standards declined from 98% to 82% in the last quarterly audit cycle at Solihull Hospital which was the largest decline in performance across all the hospital sites. Ward managers, with the support of the respective speciality's Matron, are responsible for developing and completing action plans based on the results of the audits and report progress against compliance within the monthly Care Quality agenda. Audit outcomes have demonstrated areas of operational non-compliance however there have been no patient safety incidents or harm resulting from the standards not being met. Assurance has been received that actions have been completed with immediate effect.

Immediate actions have been taken by the senior nursing managers, clinical leaders and practice educators to monitor practice, share the learning from these incidents across all UHB Quality and Safety forums/groups as well as developing a comprehensive medicines management education and training refresher for all registered nurses alongside Pharmacy and clinical practice education leads.

Monitoring of compliance against Trust standards will be undertaken locally through documentation, discharge and bedside assessments and audited weekly until practice improvement, standards and checks described in the Trust Medicines Code take place on every discharge (3.2.6 Medicines Code) and adhered to. Compliance against medicine's standards is now being reported monthly through the Hospital's Quality and Safety meetings and Safe Medication Practice Group. Any themes and practice safety risks are reported to both the Group Care Quality and Medicines Management Advisory Group.

I would like to assure you that the concerns raised within the Regulation 28 notice have been taken extremely seriously, which I hope is demonstrated in the steps that we have taken following Mr Simpson's death.

Yours sincerely



Chief Executive Officer