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Nottingham Area

Doncaster Royal Infirmary  
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Wednesday, 17 September 2025

[www.dbth.nhs.uk](http://www.dbth.nhs.uk)

Dear Dr Didcock

**Regulation 28 – Report to Prevent Future Deaths: Ms Emily Hewerdine**

I write to you with respect to the Regulation 28 Report issued on the 28 July 2025 to   
 Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust following the inquest into the death of Ms Emily Hewerdine.

The report was received by the Chief Executive's office and forwarded to me in order to provide a response.

Each concern is outlined in bold, followed by the Trust's response:

Firstly, I would like to take this opportunity to express the Trust's sincere condolences to the family and friends of Ms Emily Hewerdine.

**Concern: That patients on the wards at Bassetlaw District General Hospital (BDGH) may receive inadequate assessments of hydration status, with inaccurate and incomplete fluid balance chart documentation.**

Under the Patient Safety Incident Response Framework (PSIRF), one of the Trust's identified local priorities in 2024 was the recognition and management of the deteriorating patient. In response, a Trust-wide Safety Improvement Plan was developed, which includes targeted actions to improve fluid balance chart accuracy and hydration assessments.

Progress against this plan is monitored through the Trust's governance structures, specifically the Patient Safety Assurance Group, chaired by the Chief Nurse and attended by the Executive Medical Director.

Following Ms Hewerdine's case, the Trust commissioned a Patient Safety Incident Investigation (PSII) to identify learning and implement improvements. Measures introduced include:

- Use of Tendable, the Trust's audit and quality improvement application, enabling weekly audits and monthly oversight by the Matron. Non-compliance triggers ward-level action plans.
- Transition to electronic fluid balance charting, enhancing accuracy and enabling real-time oversight.
- Ongoing education and training initiatives led by the Division of Medicine in collaboration with the Quality Improvement team.
- Implementation of an Acute Kidney Injury (AKI) Care Bundle within the electronic patient record system in pilot areas. This includes prompts for fluid balance chart initiation and completion. Early evaluation indicates improved monitoring, with full Trust-wide rollout planned for February 2026.

**Concern: That nursing assessments, particularly in very vulnerable patients, may fail to identify deterioration, preventing timely escalation for medical review.**

In 2023–24, the Trust introduced the Care Accreditation and Recognition for Excellence (CARE) Framework, providing structured, objective evaluations of service quality. This framework supports continuous improvement and identifies areas requiring development. The Chief Nurse Oversight Framework complements this by enabling monthly reviews to detect quality triggers. This is a proactive process designed to identify areas requiring escalation and support early.

In 2024–25, nutrition-related indicators were incorporated into the CARE Framework, including:

- Compliance with MUST score assessments.
- Attendance of Link Nurses at quarterly training sessions.
- Peer review visits focused on food intake and mealtime practices.

The Trust also conducts regular Nutrition and Mealtime Peer Reviews, with findings reported to the Nutrition Action Group, which in turn reports to the Patient Safety Assurance Group. This ensures cross-divisional oversight and alignment with the Safety Improvement Plan.

To enhance communication and safety culture:

- Verbal handover processes during shift changes have been strengthened.
- Safety Huddles have been launched Trust-wide and embedded at BDGH. These evidence-based initiatives support real-time identification and escalation of safety concerns. For example, a recent huddle identified a patient declining all oral intake, prompting immediate clinical review.

Additionally, the Division of Medicine are hosting a Gastroenterology Masterclass on 7 October 2025, focusing on multi-disciplinary training. A key component was the importance of comprehensive nutrition and hydration assessments for patients with Inflammatory Bowel Disease (IBD), including accurate fluid input/output monitoring.

**Concern: That patients attending the Emergency Department at Bassetlaw DGH may not receive a clinical assessment prior to referral for mental health evaluation or prior to discharge.**

[REDACTED] Divisional Director, has formally communicated via email to all Emergency Department (ED) medical staff the requirement that **all patients attending the ED must undergo a medical review prior to any referral to mental health services.**

This process is subject to monthly audit, and the most recent audit demonstrated 100% compliance, with all patients referred to mental health services having received a documented medical review. This audit is part of an ongoing quality assurance initiative and is reported through the Audit and Effectiveness Forum to ensure sustained oversight and continuous improvement.

Finally, I hope this response provides assurance that the Trust has taken meaningful steps to address the concerns raised and remains committed to learning and improving patient safety.

Yours sincerely

[REDACTED]

[REDACTED], RN, MSc, BSc  
Chief Nurse