ACTasONE

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Date: 19th December 2025

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Trust Headquarters
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BRADFORD
BD9 6RJ

[redacted]

Mr Peter Merchant
HM Assistant Coroner
The West Yorkshire (Western) Division
Cater Building
1 Cater Street
BRADFORD
BD1 5AS

Sent via email only

Dear Mr Merchant

Re: Prevention of Future Deaths Report – Mr Alan Horrocks

Bradford Teaching Hospitals NHS Foundation Trust is in receipt of your Regulation 28 report following the Inquest into the death of Mr Alan Horrocks. We are grateful for the opportunity to learn from the issues identified during the Inquest and acknowledge the concerns to be addressed.

Firstly, the Trust extends its sincere condolences to the family of Mr Horrocks. We apologise that at the Inquest we did not provide a clear, comprehensive investigative response into any issues identified with the care provided to Mr Horrocks or offer reassurances about the steps taken to mitigate risk of recurrence. We acknowledge that what was provided was inadequate and late. We have taken a great deal of learning from this and will set out in this letter:

- Clarifications as to the issues raised in respect of the care provided to Mr Horrocks, learning identified and action taken to learn and improve; and
- Steps we have taken to improve our incident review and learning processes to avoid last minute, unhelpful investigation reports.

A Case Review Panel was convened on 14th November 2025. This was a multi-disciplinary, in-depth review of the concerns identified. Continued consideration was given to opportunities for learning and improvement derived from the issues identified in your report, but also the wider issues concerning improvements to the Trust's governance and mortality review processes. This included practical steps required to ensure improvement and mitigation of future risks, as highlighted by you, were identified. In attendance were executive officers, senior medics and nurses, and senior governance and legal leads.

<u>Those in attendance discussed:</u>

1. **Undertaking observations**. The Panel considered the guidance around this, Trust policy, and the opportunity for reflection and refresher training. It also examined the specifics of Mr Horrocks' care and the missed observations between 14th and 15th March 2025. It considered the steps taken to review the incident at the time as part of its patient safety event response, and any outstanding actions for improvement, and to reduce the risk of reoccurrence.

2. **Trust processes for increasing bed capacity on wards, and corresponding staffing plan.** The Panel acknowledged here that the inadequacy of the investigation report provided meant that the information needed to offer reassurance was not available to either you or the clinicians in attendance. We will respectfully clarify the Trust processes and hopefully reassure you that necessary steps in line with guidance were followed prior to, at the time of Mr Horrocks' admission, and continue to be followed.

3. **The Trust's Quality Improvement project – Governance, Risk and Patient Safety processes, and how it captures and triangulates patient safety events early with proactive management, clear workstreams and taking every opportunity for continuous learning.** As a direct result of improved processes, the Trust will ensure that its evidence for disclosure at Inquests and to facilitate the coroner's enquiries is forthcoming and helpful to families, other interested parties and the coroner.

1. Undertaking Observations

The Trust has undertaken a senior nursing review of the issues raised as above (1. and 2.). The National Early Warning Score (NEWS) system developed by the Royal College of Physicians standardises the recording, scoring, and escalation of changes in physiological parameters for acutely ill patients. NEWS2 is the current standard used across NHS hospitals and prehospital care.

The system allocates scores to six routinely measured physiological parameters:

- Respiration rate
- Oxygen saturation
- Systolic blood pressure
- Pulse rate
- Level of consciousness or new confusion
- Temperature

An additional two points are added for patients requiring supplemental oxygen. Escalation protocols are embedded in the electronic patient record, and all staff are trained in these protocols prior to undertaking observations.

Events on 14th March 2025:

By way of clarification, Mr Horrocks presented with a NEWS score of 3 at 18:00 on 14th March 2025, which increased to 5 at 21:00. According to the NEWS escalation protocol (which is available via the electronic patient record) this score should have triggered:

- Immediate escalation by the Health Care Assistant (HCA) to the Registered Nurse (RN) responsible for the patient
- RN escalation to medical staff for review
- Hourly observations and ongoing review.

At **06:00** on 15th March 2025 observations were repeated, and the NEWS score was noted to have increased to **8**. By way of reassurance, escalation occurred appropriately at this point:

- RN notified medical staff
- Mr Horrocks received physical examination and appropriate medical management.

Deviation from Protocol:
Neither escalation nor repeat observations occurred between 21:00 and 06:00. As identified in the investigation report, this represents a breach of the NEWS protocol and local policy.

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

This guidance is contained within the electronic record as a reminder to staff undertaking observations with regards to their responsibilities for escalation.

By way of clarification, the deviation from protocol was identified as a patient safety event on 15th March 2025. It was recorded on the Trust's LFPSE database (InPhase) at 15:17 that day.

<u>Corrective Actions Taken</u>:

Staff Management:

Once the patient safety event was recorded actions included local informal investigation, documented feedback, and mandatory **retraining** on NEWS.

Learning Dissemination:

Lessons learned were shared through ward safety huddles at every handover for the week following the reporting of the incident in March 2025. Those in attendance at ward safety huddles are all ward nursing staff on that shift. They occur every morning and every night. To ensure embedding of the actions, the incident was discussed again by Matron at the Sisters' meeting on 10th October 2025.

There was a planned discussion for the Clinical Service Unit in November, but due to the resident doctor strikes this was cancelled and has been rescheduled for December. The incident in the wider context of the inquest and the investigation response, will be discussed. This meeting is attended by medical and nursing staff, therapists and managers and ensures that all disciplines of staff are aware of the incidents and risks in the service.

The immediate learning identified, and consequent learning response actions were completed by 28th March 2025.

Audit and Assurance:

In addition, a weekly audit of 10 patient observation charts was commenced immediately following the incident being identified. No further omissions have been identified since implementation. Audit reports are retained for inspection. They are also reported to the Clinical Governance Committee.

2. *Trust Processes for Increasing Bed Capacity on Wards and Corresponding Staffing Plan*

The Trust acknowledges that the information provided via the investigation report indicated that *Ward 6 usually has 27 beds, with a nursing establishment of five registrant nurses and five Health Care Assistants (HCAs) during a shift rotation. In the period of this safety incident, due to winter pressures, the bed base on Ward 6 was increased to 33 beds with no change to the nursing establishment. During the period Mr H was on the Ward there were gaps in the nursing establishment.*

To clarify, the ward usually runs on 27 beds and has a staffing plan of five Registered Nurses and five Health Care Assistants.

On **14th March 2025** the ward operated with **33 beds.** Every year the number of patients requiring hospital admission increases, particularly during periods of seasonal pressure. To manage this demand the Trust implements a Winter Escalation Plan that includes opening additional beds. On Ward 6 this involves opening an extra bay of six beds and allocating additional staff specifically for these patients. As a result the established staffing **levels rise** from five Registered Nurses and five Health Care Assistants, to six Registered Nurses and six Health Care Assistants per shift, ensuring safe and appropriate care for the expanded patient cohort.

On 14th March 2025 the staffing for the ward was as follows:

- **Day:** six Registered Nurses, seven Health Care Assistants (morning), eight Health Care Assistants (evening)
- **Night:** six Registered Nurses, seven Health Care Assistants.

These levels exceeded the planned staffing ratios for the expanded bed base. The additional beds were opened 25th November 2024 and closed 2nd April 2025.

The Trust's Quality Improvement project – Governance and Patient Safety Processes

The Trust accepts that the investigation report filed with the court prior to the Inquest hearing was inadequate. Following the inquest the Trust has re-visited its existing Governance and Mortality Review processes, its patient safety incident response policy and plan, its learning from deaths policy and national guidance for learning from deaths, Learning from Patient Safety Events (LFPSE), and the Patient Safety Incident Response Framework (PSIRF). This formed a key part of the discussion at the Case Review Panel and at subsequent meetings with senior governance and legal leads.

Although our review panel found that our process was in line with our policies and procedures (PSIRF), we acknowledge that the transition away from traditional Root Cause Analysis/Serious Incident reports does not always meet the expectations of the coronial system.

To address this the Trust has implemented improved mechanisms by which HMC referrals are proactively reviewed on a weekly basis, and any necessary escalation for investigation is discussed and progressed via its Safety Escalation Group and its Quality of Care Panel. At both meetings operational and strategic leads in governance, legal and learning from deaths are present. There is also appropriate executive oversight of validations of harm and PSIRF learning responses required.

This approach ensures there is early, proactive triangulation between workstreams, with senior clinical and nursing input. Patient safety events are identified early, reviewed promptly and any further investigation is collaboratively undertaken utilising the PSIRF learning response tools, robustly led by clinicians and nursing staff involved in care.

To further improve upon current quality and governance processes within the Trust, it will roll out refresher training for quality governance and patient safety staff, learning from deaths leads, and legal staff regarding PSIRF, national guidance on learning from deaths and ensuring that the coroner's requirements for inquests are appropriately understood and met in the context of learning responses under the framework. The training *"Maximising Learning from Incidents and Deaths – a legal view"* will take place in early 2026. The Trust is actively exploring how this can then be tailored and rolled out more widely to its nursing and clinical staff. The Trust will also implement a comprehensive *Investigation Masterclass Programme* designed to enhance the quality and depth of our investigations. The focus will include governance mechanisms that support robust investigations and will emphasise the importance of quality assurance. It is committed to its training objectives as a key part of its wider quality improvement initiative.

Since the conclusion of the inquest the Trust has undertaken a great deal of reflection and considered via its Case Review Panel the specific points of learning and improvement to be taken from the issues highlighted within your report relating specifically to Mr Horrocks' care, and as a result its wider incident triage and learning responses.

We are confident that the concerns raised in your report have been robustly considered with necessary steps taken to sufficiently reduce the likelihood of recurrence. We remain grateful for the opportunity to offer reassurance regarding our Governance Improvement processes.

Bradford Teaching Hospitals is dedicated to continuous improvement and learning, we trust this letter offers sufficient reassurance that your report has been considered with the utmost care and lessons learned will continue to be taken forward.

Yours sincerely

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Chief Medical Officer &
Consultant Urological Surgeon