Inquest touching the death of Connor Nelson

Response of Sherwood Forest Hospitals NHS Foundation Trust to Regulation 28 report to prevent future deaths

This is the organisational response from Sherwood Forest Hospitals NHS Foundation Trust (SFH) to the Regulation 28: Report To Prevent Future Deaths issued by HM Coroner, following the conclusion of the inquest touching the death of Mr Connor Nelson.

We offer our condolences to Mr Nelson's family, and we hope this response provides reassurance that the Trust recognises and acknowledges its failings and is committed to ensuring that we learn from this to prevent future deaths.

The two matters of concern raised within the report and responses for each point are as follows:

1) The lack of evidence of any improvement in the ability of Emergency Assessment Unit staff to respond effectively to a cardiac arrest

During the course of the inquest, it was formally acknowledged that there had been delays in delivering a necessary defibrillator shock to Connor during his cardiac arrest, as identified within the patient safety incident investigation. Notwithstanding the completion of a thorough investigation and the development of a subsequent action plan, a resuscitation simulation conducted on the Emergency Assessment Unit did not provide assurance that the required improvements had been made. This matter was therefore escalated to the Trust Patient Safety Incident Review Group (PSIRG) on 6th November 2025.

Following discussion at PSIRG, a supplementary action plan was formulated and disclosed during the inquest, which concluded on 18th November 2025. Further actions undertaken since the PSIRG meeting and the inquest into Connor's death in November are detailed below:

In situ skills and drills simulation sessions:
During December 2025, a total of nine simulation sessions were scheduled to be undertaken on EAU with both nursing and medical staff, with additional sessions continuing into subsequent months. These sessions were being led by the resus team and were set to include the following key topics:

- Summoning help
- Assessing signs of life
- Timely and effective chest compressions
- Bag/valve/mask ventilation
- Head tilt/chin lift
- Collection/delivery of emergency equipment
- Attaching defibrillator pads

- Timely and safe shock delivery
- Staff roles at cardiac arrest events

Of the planned sessions, six were successfully delivered, attended by 18 staff members, resulting in an average attendance of three participants per session. Three sessions were cancelled due to staffing and operational constraints. Furthermore, nine additional sessions are scheduled for January 2026. It should be noted that, owing to the small group sizes and the restricted nature of the space utilised for "in situ" training, these sessions are not directly comparable to previous simulation events. Within the limitations of the skills practised, staff performance was assessed by the trust resuscitation team to be of a satisfactory standard.

A business case for ongoing simulation training was submitted for review and on 19th January 2026 it was confirmed that the delivery of a simulation project initially targeting EAU, ward 23 and ward 24 would be commenced. Effectiveness and consideration of rolling this out to other areas will be reviewed by the Trust Resuscitation services and Medical Education Department.

Advanced Life Support Training:

Since the inquest was held the Resuscitation Council UK (RCUK) has introduced a revision to training protocols, now permitting the use of an Automated External Defibrillator (AED) during cardiac arrest demonstrations, as well as the discussion of AED usage within the CPR and defibrillation skill station as part of the Advanced Life Support (ALS) course. This updated course format became effective as of 1st January 2026 nationally, and its implementation will commence with the ALS courses, consisting of 1-day online learning plus 1 day of hands-on training with a comprehensive skill station assessment, scheduled for 21st and 22nd January at Sherwood Forest Hospitals (SFH).

Within EAU it is an established requirement that all Band 6 and 7 registered nurses complete ALS training. As of 23rd January 2026, 70% of Band 6 and 7 nurses have successfully completed and passed the ALS training. An additional 6.92% have scheduled course dates and the remaining 23.08% are currently on maternity leave and will be enrolled onto ALS courses upon their return to work.

It is recognised, that the rotation of new staff within EAU has the potential to affect training compliance rates, particularly for training such as ALS. To address this, a comprehensive plan has been implemented to ensure that all new Band 6 staff promptly receive the necessary training upon appointment. Furthermore, measures are being explored to provide existing Band 5 registered nurses looking for development opportunity therefore supporting both ongoing professional development and the maintenance of a highly skilled workforce.

ALS training compliance will now be included in the service line performance meetings monthly commencing February 2026 to enable consistent monitoring and escalation as required.

Immediate Life Support Training:
As of 23rd January 2026 91% of registered nurses working on EAU had undergone Immediate Life Support Training and the remaining 9% of staff are booked onto courses.

Similarly to the ALS training rotation of new staff has the potential to affect this compliance rate and as such there is a plan to ensure all new staff are booked onto the next available course upon commencing in their role. ILS training compliance will now be included in the service line performance meetings monthly commencing February 2026 to enable consistent monitoring and escalation as required.

Mandatory resuscitation training:
In addition, further measures have been implemented to enhance resuscitation training across all staff at SFH. Additional AEDs have been procured to facilitate the inclusion of AEDs as a practical, hands-on component within mandatory resuscitation training sessions. The introduction of this practical element will commence in April 2026, following the conclusion of the winter pause in mandatory training. This initiative will be delivered in conjunction with the E-Learning for Healthcare (E-LfH) content, which will be utilised by nursing, midwifery, and allied health professional (N,M&AHP) staff to fulfil Resuscitation Level 1 and 2 theoretical requirements, in alignment with the broader NHS training transferability plan. Simultaneously, mandatory sessions for medical staff will also be adapted to incorporate practical AED training from April 2026 onwards.

Changes to Doctor induction:
Effective from 3rd December 2025, the doctor induction programme now incorporates a dedicated session delivered by the trust resuscitation service. This session provides an overview of the adult resuscitation trolley and its contents, as well as instruction on the two defibrillator models used at SFHFT and their operational functions. The session is made available to Foundation Year 2 (FY2) doctors and higher at each entry point throughout the training year. Foundation Year 1 (FY1) doctors receive a separate induction covering the same material in July.

Review of cardiac arrests on EAU in December 2025:
To provide further assurance regarding improvements in the management of a cardiac arrest, all cardiac arrests on EAU during the period from 1st December to 30th December 2025 were reviewed by the trust resus team. It was confirmed that EAU initiated three 2222 calls (emergency calls), of these, one was categorised as a medical emergency for which cardiopulmonary resuscitation (CPR) was not required. The remaining two incidents were audited in accordance with the cardiac arrest governance process. One case raised no concerns, while the other identified issues related to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation—specifically, that although the DNACPR decision appeared to have

been made, the corresponding form had not been completed. This omission was subsequently identified and documented via an incident report on the Datix system. The resus team have provided assurance that all reported cardiac arrests trust wide are reviewed by the resus team and any feedback is initiated at the earliest opportunity to the appropriate area lead.

Support from resus advisory group:
The RCUK Quality Standard stipulates that resus advisory meetings should be held at a minimum frequency of every six months. This requirement has been met to date. Moving forward, meetings will be scheduled on a bimonthly basis. The initial meeting was planned for December 2025; however, this was postponed due to bereavement and staff sickness. The next meeting is now scheduled for February 2026, upon the return of the group chair to the Trust. The Terms of Reference and membership list are currently under review and will be circulated to the group for comment and subsequent ratification at the February meeting.

Review of action plan:
It is acknowledged that there are ongoing actions as outlined in the Patient Safety Incident Investigation Action Plan, which was included in the disclosure bundle. The Trust will continue to advance these actions, and documentation evidencing their completion will be obtained and securely stored on the Trust's Datix system alongside the relevant action ID number to provide assurance of their completion.

The Trust will assess and assure the sustainability of the actions as noted. This will be undertaken through a structured and ongoing review process led by the acute medicine leadership team, which will ensure that improvements are embedded into routine practice and maintained over time. Sustainability checks will focus on whether actions have been fully implemented, are consistently applied in day-to-day operations and continue to deliver the intended outcomes without additional short-term support or escalation.

This will be achieved through a combination of quantitative and qualitative measures, including performance metrics and feedback from staff. Ownership for sustaining improvements will be clearly assigned to the Divisional Leadership Team, with actions incorporated into business-as-usual processes such as policies, standard operating procedures, ongoing training programmes, and governance reporting cycles.

Where evidence indicates deterioration or risk to sustainability, this will trigger early escalation, review, and corrective action. This approach ensures that regulatory actions and transformation improvements are not only delivered but are durable, resilient, and continuously reinforced

2) The lack of understanding by medical staff, of the importance of identifying prolonged QTc syndrome in patients attending KMH, with a lack of a robust

process for ensuring necessary referral and investigation of the condition by the KMH Cardiology team.

During the investigation into the patient safety incident, it was determined that there were knowledge gaps in the recognition and management of Long QT syndrome among medical staff. Actions were subsequently implemented to enhance both the identification and treatment of this condition as detailed within the inquest. The inquest highlighted additional opportunities to reinforce and strengthen the actions already taken, and these have been addressed by the cardiology team to further improve patient safety as follows:

Recognition of Long QT:

With regard to the recognition of Long QT syndrome, it was noted that there were several missed opportunities to identify a prolonged QT interval on Connor's ECGs as the QT did not appear to have been measured. On 22nd January 2025, a dedicated teaching session was conducted for medical staff at Grand Round, led by the cardiology team, which specifically addressed the methodology for measuring the QT interval and the relevant cut-off values. To support the ongoing sustainability of this training, the accompanying PowerPoint presentation has been disseminated to all current medical consultants, to enable regular educational sessions to be maintained for the broader medical team. In addition, across all specialty and divisional governance reports in February 2026 information on the importance of measuring QT when undertaking an ECG will be included as a hot topic for further trust wide learning and signposting to the Prolonged QT Interval Identified on ECG in Adults Pathway.

The governance support unit will continue to monitor incidents for trends and themes and ensure any concerns with incidents regarding recognition of Long QT are escalated to the appropriate specialty for review.

Knowledge of drugs which impact on QT:

Since the inquest, the Cardiology team has collaborated with both the Pharmacy team and the Electronic Prescribing and Medicines Administration (EPMA) team to submit a proposal for a notification alert within the EPMA system. If development of an alert is possible the alert would be activated when a medication with the potential to prolong the QT interval is prescribed, thereby prompting the prescriber to review the patient's medical history and consider alternative treatments if a diagnosis of long QT syndrome is present. Given the complexity associated with identifying all medications that have the potential to prolong the QT interval, as well as the ongoing requirement to maintain and review this list when new drugs are introduced, the development of this alert system may present additional risks and challenges. Accordingly, the outcome of this proposal will be brought before the Patient Safety Committee in March 2026, at which point further actions will be determined and subject to ongoing monitoring.

Management of Long QT:

During the patient safety incident investigation, it was identified that there was a knowledge gap regarding the management of Long QT and the Prolonged QT Interval Identified on ECG in Adults Pathway was developed which outlines the causes,

investigations and treatments required for patients with Long QT. The pathway was issued on 29th September 2025 and was immediately made available to all trust staff via the intranet when searching “long QT”.

During the inquest, the introduction of this new clinical document was duly noted. However, concerns were raised regarding its level of detail, particularly in relation to its suitability for staff without specialised experience in cardiology. Consequently, amendments have been implemented to address these concerns, as reflected in the draft pathway provided in Attachment 2. The draft pathway is progressing through the specialty and divisional sign off process with an anticipated completion date at the end of February 2026.

Summary of amendments to the new pathway:

1) The pathway now incorporates an assessment of the likelihood of hereditary factors, including genetic predisposition and family history. Where hereditary risk is unknown, the pathway advises the clinical to proceed via the 'no' route.

2) Criteria have been defined for referral to cardiology services, distinguishing between urgent, inpatient, and routine referrals in accordance with clinical necessity.

3) The pathway outlines the process for repeating electrocardiograms (ECGs), specifying circumstances under which repeat testing is indicated and when.