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Teaching Hospitals
NHS Foundation Trust

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5 March 2026

**STRICTLY CONFIDENTIAL – ADDRESSEE ONLY**
Ms N J Mundy
Senior Coroner for South Yorkshire (East District)
Coroner's Court and Office
Crown Court
College Road
Doncaster DN1 3HS

Dear Ms Mundy

**Dennis Keith Price (deceased)**

I write to you with respect to the Regulations 28 Report issued on the 20 January 2026 to Chief Executive of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust following the Inquest into the death of Dennis Keith Price concluded on the 12 January 2026.

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

I have been assisted in constructing this response by Dr Youssef Sorour, Associate Medical Director for Clinical Safety and Marie Hardacre, Associate Chief Nurse for Patient Safety & Quality.

I would respond to the matters of concern referred to within the PFDR as follows:

**1. Failure to properly complete the inpatient post fall review**

A Trust Patient Falls Prevention and Management Policy (PAT/PS 11) is in place and is readily accessible via the Trust intranet. This policy provides clear guidance for healthcare professionals on the management of inpatient falls, including the requirement for appropriate neurological observations following a fall. Following the tragic death of Mr Price, it has become apparent that, although healthcare professionals acted in accordance with the policy, the associated documentation—specifically the Inpatient Post-Fall Review—was not fully completed.

Accurate, timely and comprehensive documentation following an inpatient fall is essential to ensure patient safety and to demonstrate that appropriate clinical assessment and ongoing monitoring have been undertaken. In particular, the clear and complete recording of post-fall assessments, including neurological observations where indicated, is critical to support early identification of deterioration, inform clinical decision-making, and enable effective communication across the multidisciplinary team. The Inpatient Post-Fall Review serves as a key clinical record, providing assurance that required assessments have been completed in line with Trust policy. The Trust recognises that failure to fully complete required documentation may undermine these objectives, even where appropriate clinical actions have been taken.

The Trust recognises that training is fundamental in reinforcing the importance of complete, accurate and contemporaneous clinical documentation, and this remains a core component of all education delivered by the Patient Safety Team. In addition, targeted documentation training has been delivered by the Trust's Solicitor/Legal Manager to Foundation Year 1 doctors on 11 September 2025, and to Preceptorship Nurses on 11 and 25 November 2025. This programme of education forms part of an ongoing initiative, with further lectures and seminars planned to ensure continued reinforcement of documentation standards across the organisation.

2. **No clear plan for frequency of neurological observations and duration of the same and associated lack of clear direction from the attending Doctor following a fall**

The Trust acknowledges the concern regarding the absence of consistently documented medical direction for the frequency and duration of neurological observations following Mr Price's fall. While the Patient Falls Prevention and Management Policy (PAT/PS 11) provides guidance on post-fall management, learning has identified the need for clearer, explicit documentation by the attending doctor to ensure that neurological observation requirements, review arrangements and escalation plans are clearly defined and understood by the multidisciplinary team. As part of ongoing improvement, the Trust is reinforcing the expectation that a clear, individualised post-fall monitoring plan is documented following every fall, supported through strengthened documentation standards, targeted multidisciplinary training and continued emphasis on completion of the Inpatient Post-Fall Review.

3. **The efficiency of the Nerve Centre system escalations in that any triggers must be followed up and properly completed on the system for the nerve centre system to be fully effective**

The Trust recognises the importance of the Nerve Centre system in supporting timely escalation and clinical decision-making and acknowledges the concern raised regarding the effectiveness of escalations where system triggers are not fully completed. Review of Mr Price's care identified a documentation gap within Nerve Centre, specifically the absence of a recorded name confirming to whom the escalation was made, which limited assurance that the escalation process had been completed as intended. For the Nerve Centre system to function effectively, it is essential that all triggers are acted upon, followed up and fully documented, including clear identification of the clinician to whom concerns are escalated. As part of ongoing learning, the Trust is reinforcing expectations around the completion of Nerve Centre escalation records, supported by targeted training and renewed emphasis on accurate, contemporaneous documentation to strengthen patient safety and system reliability.

**Summary of Actions**

1. **Documentation and Training:**

   Targeted multidisciplinary training is being delivered and reinforced to promote accurate, complete and contemporaneous clinical documentation, with particular emphasis on post-fall documentation and

neurological observations. Documentation standards remain a core component of Patient Safety Team training, with additional sessions delivered by the Trust's Solicitor/Legal Manager and further education planned on an ongoing basis.

2. **Post-Fall Medical Direction and Neurological Observations:**

   The Trust is reinforcing the requirement that, following an inpatient fall, the attending doctor must document a clear, individualised plan for neurological observations, including frequency, duration, review and escalation criteria. This expectation is being embedded through strengthened post-fall documentation standards and targeted multidisciplinary education.

3. **Nerve Centre Escalations:**

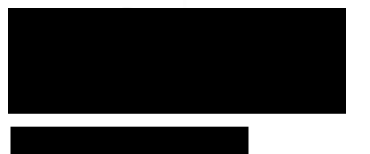
   Use of the Nerve Centre system is being reinforced to ensure that all escalation triggers are actioned, followed up and fully completed, including clear documentation of the name and role of the clinician to whom escalation is made. Targeted training and renewed emphasis on accurate system documentation are being implemented to improve reliability, assurance and patient safety.

**Conclusion**

By implementing the proposed recommendations, the Trust has an opportunity to strengthen the quality and consistency of clinical documentation. Improved documentation will enhance clarity of clinical decision-making, support effective multidisciplinary communication and provide greater assurance that care is delivered in line with Trust policy. Collectively, these improvements will contribute to safer care delivery and, ultimately, to improved patient outcomes.

I trust this information provides reassurance that learning from Mr Price's case will lead to improvements in pathways and processes, ultimately strengthening patient safety.

Yours sincerely



Acting Executive Medical Director

Cc: , Chief Executive
Associate Medical Director for Clinical Safety
Associate Chief Nurse for Patient Safety & Quality