

Dear Assistant Coroner Robinson

Our Ref: LS/KD/240326/L1

24 March 2026

Hull Royal Infirmary
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Hull
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Email: [REDACTED]

Strictly Private and Confidential

Miss Sally Robinson
East Riding and Hull Coroners
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Regulation 28 Report to Prevent Future Deaths – Mrs Patricia Irene Walker

Thank you for your Regulation 28 Report to Prevent Future Deaths dated 27 January 2026, issued following the inquest into the death of Mrs Patricia Irene Walker.

We again express our sincere condolences to Mrs Walker's family.

We recognise the Coroner's concern that staffing on Ward 90 was sub-optimal due to recruitment difficulty, meaning that "TAG nursing care is not always possible" and that patients are therefore at increased risk of falls.

While the concern is identified in relation to Ward 90, the Trust agrees that safe nurse staffing and the ability to deliver consistently high standards of fundamental care is a Trust-wide patient safety priority, particularly across inpatient wards where acuity, dependency and operational pressures have increased.

1) Summary of the Trust-wide actions taken

The Trust has established daily operational controls to mitigate staffing pressures in real time. Daily staffing meetings take place across all sites, where ward-level escalations relating to actual versus planned staffing, changes in acuity, and red flag indicators are reviewed by dedicated staffing representatives. These representatives cover all Trust sites, providing a consistent view of risk and enabling rapid redistribution of workforce to the highest priority areas.

Information from these meetings feeds directly into twice-daily Trust-wide safe staffing meetings chaired by a Nurse Director, providing senior clinical oversight of staffing gaps, mitigations and risk management. Subject matter specialists in enhanced care attend to advise on patients requiring enhanced observation, specialising or alternative care models, and site matrons attend to ensure alignment between staffing decisions, patient flow and operational pressures.

Out of hours, staffing escalations are directed to site matrons who provide senior clinical leadership 24 hours a day, 7 days a week, and who review and authorise redeployment, temporary staffing requests and enhanced care arrangements during evenings, nights and weekends, ensuring continuous oversight and rapid response to any deterioration in staffing levels or patient acuity outside core hours.

In addition to the above, as part of a wider programme to strengthen safe staffing and reduce reliance on temporary mitigation, the Trust (as part of Humber Health Partnership) has undertaken a comprehensive safer staffing establishment review using recognised safer staffing tools (including the Safer Nursing Care Tool census approach) and triangulation with patient outcomes.

This work identified:

- There is a gap between baseline establishments and assessed requirements across inpatient areas (predominantly on the Hull Royal site), emergency departments, and some community nursing services when assessed against the available safer staffing tools; and that the Trust is in the bottom quartile nationally for CHPPD.
- a structured RAG prioritisation of areas for investment, using professional judgement and outcome triangulation.
- that funding the “red” areas would require investment, equating to 123.82 WTE, and that this is intended to support safer care delivery and reduce premium “bad cost” spend by moving to substantive recruitment where possible.

The review findings and recommendations were considered by the Trust Boards-in-Common, and the Boards approved the nursing establishment investment, including funding for red-rated areas as a priority for patient safety.

The Boards further agreed that, where the investment enables substantive recruitment into specific areas, bank and agency usage should reduce accordingly and will be monitored, with clear accountability where usage increases again.

2) Trust-wide approach to reducing falls risk and strengthening fundamental care delivery

The Trust recognises that low staffing levels and skill mix gaps can directly affect the ability to provide consistent fundamental care (including observation, rounding, toileting support, and timely response), which in turn can increase falls risk for frail patients.

Accordingly, the Trust-wide programme includes:

- Targeted investment in inpatient wards (prioritised via RAG) to strengthen day and night staffing, particularly non-registered workforce where gaps drive reliance on short-term mitigations.
- Reducing inappropriate 1:1 mitigations: the paper notes use of security bed watch staff for patients requiring one-to-one supervision, acknowledging this can be inappropriate and linked to reduced non-registered nursing capacity; the intention of investing in the non-registered workforce is to reduce reliance on this mitigation and improve patient experience.
- Standardised oversight of enhanced observation: all patients requiring security bed watch are assessed every 24 hours by a specialist registered nurse (7 days/week), with support to clinical areas to ensure patients are cared for in the most appropriate way.

- Strengthened staffing governance and assurance: the review work included an assurance site visit by the Regional NHS England team at Hull Royal Infirmary in November 2025, who were assured by the safe staffing processes undertaken to identify staffing requirements and recommendations.

3) How this addresses the Ward 90 concern

While the Trust's actions are Trust-wide and intended to improve safety across multiple wards/services, the approved investment recommendations do include Ward H90, which is identified as SNCT Red with a recommended uplift the number of Health Care Assistant 12 hours per day.).

We hope this provides assurance that the Trust is not only addressing safe staffing at system level but is also implementing targeted improvements in the frailty ward setting relevant to the concerns.

4) Timetable for implementation (Trust-wide programme)

The Trust-wide programme will be implemented on a phased basis, prioritising areas assessed as "red" through the safer staffing review, and aligning investment to recruitment and affordability planning.

5) Monitoring and assurance

The Trust will monitor the impact of these actions through staffing and quality measures, triangulated with patient outcomes and incident learning, including temporary staffing usage, staffing fill rates, and patient safety indicators such as falls (including falls with harm), particularly across frailty wards.

The Boards have also agreed strengthened governance and reporting arrangements, including receipt of a safer staffing paper every six months, with the next report scheduled for April 2026. Future reports will include benchmarking against peers and KPIs to evidence the outcomes and benefits of the approved investment, including a baseline position and expected improvements following implementation.

The Executive Team will report to the Workforce, Education & Culture Committees-in-Common on how the staffing investment will be managed, including expectations around redeployment and the planned reduction and ongoing monitoring of bank and agency usage.

In closing, the Trust recognises the importance of the matters raised and is committed to providing assurance that safe staffing is being addressed both at ward level and across the wider organisation. The Board-approved Safer Nurse Staffing Establishment Review and associated governance actions provide a Trust-wide framework to identify risk, prioritise investment and strengthen establishments, supported by ongoing triangulation of staffing information with patient outcomes and incident learning.

Yours sincerely



Interim Group Chief Executive