Response to Regulation 28 Request

Title	Coroner Regulation 28 – Prevention of Future Deaths Report into the death of Linda Brooks
Author/Role	[redacted] Associate Director of Patient Safety and Quality
Accountable Executive Director	[redacted] Chief Nurse

Concerns raised by the coroner leading to the Regulation 28 – Prevention of Future Deaths Report:

Linda Brooks was a 78-year-old lady who died at Torbay Hospital on 17th May 2022. She had resided at Sundial Care Home since 2018. She fell in the care home in February 2022, where she possibly sustained fractured ribs. She did not want to seek a chest X-ray, but family/doctor persuaded her to do so. Prior to this she fell again on a background of COVID infection, which resulted in her being admitted to Torbay Hospital on 16th April 2022, where she remained until her death.

On the day prior to Mrs Brooks' death, she was an inpatient at Newton Abbot Community Hospital (part of Torbay and South Devon NHS Foundation Trust). Mrs Brooks was being weaned from oxygen prior to her discharge, and at the time she was on 0.5 litres of oxygen via nasal cannula. At some point during the evening of 16th May 2022 this oxygen was inadvertently turned off. It appears that the oxygen had been turned off for a period of time between 20:07 and 21:30. By 21:30 Mrs Brooks' oxygen saturations had dropped significantly. The out-of-hours GP service was called and, due to the delay in attending, a 999 call was also made.

An out-of-hours doctor visited Mrs Brooks at 03:30 and diagnosed Mrs Brooks with an infective exacerbation of COPD and commenced intravenous antibiotics and intravenous frusemide. The GP documented that he did not think Mrs Brooks required transfer to an acute hospital and advised he would remain in contact via telephone as needed.

The registered nurse remained concerned about Mrs Brooks' condition, and her Treatment Escalation Plan noted that transfer back to an acute hospital would be appropriate. The 999 call had not been cancelled and South West Ambulance Service (SWAST) transferred Mrs Brooks from Newton Abbot Community Hospital to Torbay Hospital, arriving at approximately 05:30. She was moved to the resuscitation area of the Emergency Department.

Mrs Brooks did not respond to treatment within the Emergency Department; she was placed on the end-of-life pathway and was transferred to Forrest Ward. Mrs Brooks' death was confirmed at 00:15 on 18th May 2022.

An inquest into Mrs Brooks' death was held on 28th and 29th January 2026. Following the conclusion of the inquest, the coroner issued a Regulation 28 Prevention of Future Deaths report. The **matters of concern** raised by the coroner are detailed below:

1. *There appeared to be a lack of training and understanding by staff at the Trust that it is everybody's responsibility to report and escalate a serious clinical incident such as this*
2. *2. There appears to be no effective process in place for reviewing clinical notes to pick up a clinical issue such as this in circumstances where no complaint has been made by a family member, and no member of staff has recognised or reported it.*

3. *3. There appears to be a lack of understanding as to when a Serious Incident Report should be made or actioned retrospectively.*
4. *4. There appeared to be no process for recording the fact that another organisation such as SWAST had made a Datix referral which would then have mitigated the fact that the SWAST team failed to pass on their own DATIX to Torbay and South Devon NHS Trust.*

Background:

Linda Brooks was a 78-year-old lady who lived in a care home and had the following comorbidities: health anxiety, COPD, asthma, and ischaemic heart disease. She had a fall at her care home which caused an admission to Torbay Hospital on 16th April 2022.

Initially no fractures were seen, and she was treated with oxygen therapy at lower levels than would be seen in a person without respiratory compromise because too much oxygen can cause a reduction in respiratory drive and further CO_2 retention in COPD patients.
She was transferred from the Emergency department to Forrest Ward where rib and pubic Rami fractures were diagnosed and it was discovered that she had small blood clots. On 22nd April 2022 it was felt that given her high risk of falls and co-morbidities, the risks of potential bleeding if on anticoagulation, meant that the blood clots should not be treated, and therefore she recommenced prophylactic clot prevention dose Dalteparin.

On 29th April 2022, multiple gastric erosions and three duodenal ulcers were diagnosed and treated accordingly. An increase in oxygen requirement on 4th May 2022 with a new change on chest X-ray led to an increase in her diuretic therapy and a switch to a stronger form of intravenous antibiotic for hospital-associated pneumonia. Her oxygen requirements fluctuated during the admission. Multiple blood gases showed that she remained very sensitive to over-oxygenation, which would cause her to hyperventilate further; therefore, it was recommended that she remain at target oxygen saturations of 88–92%. She was gradually weaned to oxygen via nasal cannula. There was a steady improvement in inflammatory markers, and she was discharged to Templar Ward at Newton Abbot Community Hospital on 10th May.

By the 13th of May 2022 she had weaned to a minimal level of oxygen 0.5l, she was found to have a new irregular heart rhythm, known as atrial fibrillation.

Mrs Brooks was stable, eating, drinking and mobilising well and appeared to be improving sufficiently to begin the process of returning home when, on 16th May 2022, a note in the nursing records stated that Mrs Brooks' oxygen had been turned off. This appears to have happened sometime between 20:07 and 21:30, when it was noted that oxygen was not turned on at the wall. Asked about whether someone could have knocked the dial inadvertently, the consensus was that it was not easily done, and certainly not easily done by a frail patient such as Mrs Brooks. The Hospital Matron was able to say that at 21:30, when this was discovered, Mrs Brooks' oxygen saturation levels had dropped to a very low level as confirmed by the Consultant, well below even the lowest levels recommended for COPD patients (88%), namely 74%. A patient safety

incident was not raised at the time, and the Trust acknowledges this oversight and accepts that an incident should have been raised on the DATIX reporting system at the time and, failing that, should have been made retrospectively (this has now been completed post-inquest).

SWAST attended to convey Mrs Brooks to the acute hospital and reported an incident on their local risk management system (LRMS) as they were concerned that the incident had happened and about the attitude of staff at the hospital, but due to human error this incident was never shared with Torbay and South Devon NHS Foundation Trust although there was an established process for that to happen.

Mrs Brooks was seen at the acute hospital where she sadly passed away on 17th May 2022 and the Consultant who gave evidence at inquest accepted that she did not complete an incident on DATIX or any other type of report and neither did she escalate this concern as the ambulance service had already done so.

The Inquest was not able to confirm how this error had happened as it was never investigated contemporaneously or at all.

TSDFT response to HM coroners Matter of Concern 1

1. *There appeared to be a lack of training and understanding by staff at the Trust that it is everybody's responsibility to report and escalate a serious clinical incident such as this*

Response

To ensure it is everybody's responsibility to report and escalate serious patient safety incidents, the Trust has strengthened its patient safety governance, training, and reporting infrastructure.

These roles support our clinical staff with the reporting of incidents, including education and training sessions for clinical staff, including medical staff. We have also just recruited 3 new Care group Director of Nursing roles to lead governance within our care group structures and to support patient safety.

The Trust have policies in place to support patient safety oversight within the organisation. These policies reference the expectation for staff in relation to the reporting of clinical incidents and the engagement of patients and families. These policies are:

- The Incident Reporting and Management Policy [G0848]
- Duty of Candour Policy [G2783].

The implementation of Patient Safety Incident Reporting Framework (PSIRF) gave a renewed focus on the importance of incident reporting to enhance safety insight. The Trust recognises that reporting and reviewing of incidents is crucial to the transition and embedding of PSIRF, this includes the importance of reporting unexpected patient safety events.

A new reporting system [DCIQ] was implemented in the Trust in October 2023; the importance of reporting incidents formed a large part of the communication plan around this system.

The Patient Safety and Incident pages on the Trust intranet state that "*All staff are able and encouraged to report any unexpected or unintended incidents on DCIQ; permission from leaders/managers is not required*". The Patient Safety Team also presents at Trust induction for new starters to reinforce that safety is everyone's business and that anyone can raise an incident.

The Trust embraces a 'Fantastic Fundamentals' series, these 30-minute, monthly presentations cover what is required to meet the basic health requirements we must deliver for our patients and include presentations from the patient safety central team on incident reporting, duty of candour and patient feedback.

In July 2022 the Trust implemented a weekly Patient Safety Incident Report Group (PSIRG) to review patient safety incidents and reporting trends, risks, and emerging themes, with multidisciplinary attendance and routine care group presentations. Key learning and insights are shared via a bi-monthly Patient Safety Newsletter on the intranet and through the twice-weekly ICON email bulletin.

All staff are asked to complete the National training: 'Essentials of Patient Safety: For all staff (Level 1 Part 1)' every 3 years. 'Essentials of Patient Safety: Access to Practice (Level 2)' are available on the Trust's learning and development hub [the Hive], with Level 1 being essential to role. The percentage of compliance as of 19 March 2026 date was 83.69%

A report showing the patient safety event data from Q1-3 2025/26 by NHS Trusts showed that TSDFT had the highest incident reporting of any acute trust in the Southwest and 14th nationally, highlighting a positive reporting culture influenced by a just, learning culture.

Since the inquest, additional community-hospital training and targeted communications have been delivered to reinforce incident reporting expectations, and a quarterly learning event programme will commence from June with incident reporting as a core topic. Effectiveness is monitored by the central Patient Safety Team through DCIQ reporting volumes and training compliance, reviewed monthly via PSIRG and escalated through care group governance where required.

TSDFT response to HM coroners Matter of Concern 2

2. *There appears to be no effective process in place for reviewing clinical notes to pick up a clinical issue such as this in circumstances where no complaint has been made by a family member, and no member of staff has recognised or reported it.*

Response

To ensure clinical issues are identified even when no complaint is raised, the Trust now uses the Medical Examiner (ME) review process to systematically review deaths and associated records.

The ME's actively report identified concerns or concerns raised by the family onto DCIQ and highlight cases to request a structured judgement review is undertaken where care factors may have contributed to the death.

These are then reviewed by governance leads in the care group and scored on the DCIQ SJR system, with any scoring 1 or 2 triggering being considered for further investigation. These structured judgment reviews will be considered at the weekly executive review meeting for consideration of a more detailed patient safety review or patient safety incident investigation in line with local and National PSIRF priorities.
Effectiveness is monitored by the ME service and care group governance leads via completion of ME reviews and the number/timeliness of DCIQ submissions and SJRs, reviewed weekly at the Executive Incident Review Meeting (EIRM).

TSDFT response to HM coroners Matter of Concern 3

3. *There appears to be a lack of understanding as to when a Serious Incident Report should be made or actioned retrospectively*

Response

To clarify when incidents require investigation (including retrospectively), the Trust has adopted PSIRF and uses a weekly Executive Incident Review Meeting (EIRM) to determine and govern the appropriate response.

PSIRF advocates a co-ordinated, data driven and proportionate response prioritising compassionate engagement and involvement with staff, patients, families and carers.

The Trust have a weekly Executive Incident Review Meeting [EIRM] where all incidents of which are rated moderate or above are reviewed, alongside any themes or trends from all incidents. The level of investigation is determined by care groups and overseen by the EIRM. The level of investigation is based on National and local PSIRF priorities for patient safety incident investigation. National priorities include (but are not limited to) any case where care factors are considered to have contributed to the death of a patient. This provides reassurance and governance. These incidents are also reviewed in the Care Groups. Local priorities for Trust patient safety incident investigation are delays associated with patient flow (ambulance, corridor care, admission to stroke unit etc); diagnostic delays or errors; patient discharge related incidents.

The Trust PSIRF policy and plan is available to access on the internet and was updated in January 2026 following new safety insight data.
Effectiveness is monitored by the EIRM through review of all moderate-or-above incidents and confirmation of agreed investigation route and completion, reviewed weekly with actions tracked through care group governance.

TSDFT response to HM Coroners Matter of Concern 4

4. *There appeared to be no process for recording the fact that another organisation such as SWAST had made a Datix referral which would then have mitigated the fact that the SWAST Team failed to pass on their own DATIX to Torbay and South Devon NHS Trust.*

Response

To ensure incidents raised by partner organisations (e.g., SWAST) are reliably captured and actioned, the Trust operates a defined process to receive external referrals, log them on DCIQ where needed, and route them for investigation.

Upon receipt of the incident, it is investigated by the appropriate team, this could be within Care Group/Service, or if a Patient Safety Incident Investigation [as agreed by EIRM], by a trained PSII Investigator.

Once the investigation has been completed the outcome and learnings are shared with the organisation that reported it.

The same process occurs when we identify an incident related to another organisation.

In addition, the Trust's incident reporting system is compliant with the national Learning from Patient Safety Events (LfPSE) service, supporting cross-organisational routing of incident reports where the incident occurred in another organisation.

LfPSE includes functionality to indicate whether an incident occurred in the reporter's organisation or another organisation, enabling forwarding to the relevant organisation; this functionality was not available at the time of this event.

The most recent LfPSE data extraction (05 March 2026) showed Torbay and South Devon NHS Foundation Trust as the top acute trust reporter in the Southwest and the 16th acute trust in the country; NHS England notes that higher reporting rates may reflect a more open learning culture rather than reduced safety.
Effectiveness is monitored by the central Patient Safety Team via volume and processing timeliness of externally sourced incidents (including SWAST referrals) received and logged on DCIQ, reviewed monthly with outcomes fed back to the reporting organisation.