



**RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS**

**REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013**

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	<p style="text-align: center;"><b>RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS</b></p> <p style="text-align: center;"><b>REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013</b></p> <p style="text-align: center;">(Please do not include any living persons' names in this document, in accordance with the Chief Coroner's <a href="#">PFD Publication Policy (2026)</a>)</p> <p>THIS RESPONSE IS BEING SENT TO:</p> <p><b>HM AREA CORONER EMMA BROWN</b> for Birmingham and Solihull in response to a '<b>REPORT TO PREVENT FUTURE DEATH REGULATION 28</b>' following an inquest into the death of <b>JOHN MCKINLAY</b> that concluded on <b>30 APRIL 2026</b>.</p>
1	<p><b>RESPONDENT</b></p> <p>In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, <b>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</b> provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths</p>
2	<p><b>DATE OF RESPONSE</b></p> <p>4 June 2026</p>

## CONFIRMATION OF CORONER'S MATTERS OF CONCERN

The **MATTERS OF CONCERN** were identified in the report as follows:

3 The evidence from witnesses was that Mr McKinlay had a total of 4 falls whilst an inpatient at the University Hospitals of Birmingham: on the 11th September 2025 at Good Hope Hospital, 28th September 2025 at Birmingham Heartlands Hospital and on the 10th and 12th November 2025 at Queen Elizabeth Hospital. Some, potentially all, of these falls occurred when Mr McKinlay was not receiving the appropriate level of observation in accordance with his falls risk assessment and care plan. He sustained a femur fracture requiring operative fixation from the fall on the 11th September and an acute bleed of a pre-existing subdural haemorrhage on the 28th September. He did not have any investigations into the November falls as he was already receiving end of life care and there was no clinical evidence of injury. There has been a mortality review of the events at Good Hope Hospital, including the fall on the 11th September. However, evidence has not been provided of investigations into the falls at Birmingham Heartlands Hospital and Queen Elizabeth Hospital. It therefore cannot be determined that appropriate lessons have been learnt and adequate action taken creating a risk if the situation has not improved.

- 1) The number of falls occurring when the Deceased did not have supervision in accordance with his falls risk assessment.
- 2) The absence of evidence of a thorough investigation into all the falls with learning points and an action plan.

**DETAILS OF ACTION TAKEN**, how has the concern been addressed.

(If no action is proposed please explain why here)

Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

4 During Mr McKinley's admissions within our Trust we regret that he did fall on four separate occasions. All relevant risk assessments had been undertaken during each admission and following any move between sites and wards. Assurance is provided that there was a thorough review undertaken following each fall with learning and actions being taken where appropriate. Further details are set out below.

All patient falls within our organisation are reviewed locally and also centrally by our governance and falls teams. We have a dedicated falls team and part of their role is to review every reported incident where a patient has suffered a fall. The service runs Monday to Friday. Each of Mr McKinley's falls were incident reported and reviewed by a member of the falls team in a timely manner prior to the incident being closed.

Witness evidence was provided to the Coroner's office in the form of a statement prepared by a Senior Sister at Heartlands Hospital, dated 16 December 2025. The senior sister received a schedule 5 notice to attend the Inquest. The statement outlined the investigations that had been undertaken following the fall on 28 September and the actions that had been taken. A de-warn notice was subsequently received from the Coroner's office in relation to the Senior Sister's attendance at Inquest.

Below is a summary of each fall together with details of the investigation that was completed and any appropriate actions taken.

### **Fall on Thursday 11 September 2025 – incident report completed**

Mr McKinley had a fall at 16.05 hours and he was reviewed immediately by a doctor and their findings recorded on our electronic noting system (PICS) at 16.10 hours. They recorded a medical plan including a request for imaging. Mr McKinley's daughter was contacted at 17.11 hours and informed of the fall.

Following the reporting of the incident, automated emails were sent to the Consultant and Clinical service lead for Stroke, Lead Therapist for Good Hope Hospital (GHH), Nurse for ward 28, Matron for ward 28, the whole falls team (x 5 members) and the whole of the clinical governance team.

The falls team reviewed the incident the same day and graded the severity of harm as severe. An email was sent to the ward team and clinical governance team informing them that the falls team would scope the incident formally.

Mr McKinlay was transferred to ward 18, a trauma and orthopaedic ward, at Heartlands Hospital (BHH) and underwent surgery for fixation of the fracture on 13 September 2025.

Formal scoping of the incident was completed by the falls team on 15 September 2025 and emailed to the ward and clinical governance teams outlining what they believed the contributory factors were for the fall and any immediate gaps in care that might have been contributory. The falls scoping process looks at every aspect of the patient falls assessment and management on the ward, from assessments that were completed on admission to the ward, what interventions were put in place to reduce the risk of falling, to how the patient was retrieved from the floor, imaging and whether this was completed in a timely manner, administration of analgesia, etc.

As set out within the Senior Sister's statement shared with the Coroner's office on 16 December, she spoke to staff to ascertain how the fall occurred. In response, staff reflected that they had undertaken a handover outside of the bay instead of inside the bay which ultimately led to Mr McKinlay being able to get up unaided. The whole team were reminded of the importance of staying in bays during subsequent daily safety huddles. Stay in the bay arm bands were also introduced in order to reinforce this further. The Senior Sister continues to monitor compliance with this and the falls team have confirmed that they have received no further incidents from this ward in relation to falls occurring when staff are leaving their designated area to handover.

A Listen Learn Share form was also completed with the learning identified and actions required and this was circulated to all staff to read.

A summary of the incident and findings from the scoping were also presented at a weekly Patient Safety Incident Review Group meeting on 8 January 2026. This meeting is chaired by a Deputy Chief Medical Officer and attended by specialty medical directors, senior nursing teams and governance leads. After considering the incident, the group concluded that there was no requirement for a formal investigation as the incident had already been thoroughly reviewed locally and the team had already reflected on the incident and put appropriate actions in place to prevent a similar incident occurring.

#### **Fall on 28 September 2025 on Ward 18 BHH: incident report completed**

Mr McKinley fell at 00.53 hours. He was appropriately reviewed by the clinical team who noted their findings and requested imaging. The incident was reported at 04.57 hours with automated emails being sent to the ward manager, ward sister, Matron, falls team, clinical governance and trauma nurse practitioner team. Mr McKinley's daughter was informed of the fall at 07.30 hours.

During the Inquest the Coroner asked the consultant present to comment on whether the imaging report of an acute on chronic subdural bleed could be attributed to the second fall, and they agreed that the acute component could be attributed to the second fall. The Coroner concluded that both the first and second fall were contributory to the patient's deterioration.

At the time of the fall the CT scan had been reviewed by the neurosurgical team on 28 September 2026 and they documented the following in Mr McKinley's notes:

*NORSe Neurosurgery response:*

*Clinical information noted and the images seen.*

*Overall, there's been significant improvement in the initial CT findings:*

- 1. Right ASDH has since chronified and improved, now chronic and volume is well reduced.*
- 2. The right temporal contusion has since chronified as well*

*Overall, no neurosurgical intervention is required.*

The falls team reviewed the incident on Monday 29 September 2025 and the incident was deemed to be low harm in light of the NORSe neurosurgery review above, therefore, no further investigation was deemed to be required by the falls team and this remained for local investigation by the ward team.

As per usual process during the falls team review, they looked at the circumstances of the fall as per the patient records and the incident report form, observations that had been carried out, and the risk assessments to ensure these had been completed and were in date, alongside any imaging reports.

On the same day, the incident was reviewed by the senior sister and discussed with the staff involved to understand the circumstances surrounding the fall. The findings concluded that as Mr McKinlay had been settled in the days leading up to his fall, staff had been conducting frequent checks on him rather than remaining in line of sight, which was deemed appropriate at that time given his presentation and observations that his cognitive impairment had been improving. In response to her investigation, the senior sister created a Listen Learn Share form outlining the learning and actions required to reduce the risk of a similar fall occurring again. This included that the post fall neurological observations had not been completed entirely to time and frequency as set out in the Trust standards, that some risk factors had been missed from the falls risk assessment, but despite this, others that were captured did highlight the patient as being at an increased risk of falling, that staff could have completed a deprivation of liberty post fall, and for staff to ensure they are using bed rails appropriately. This was shared with the whole ward team via a RADAR alert. This is an alert sent to staff electronically. The senior sister then closed the incident following her local investigation and implementation of actions, which was appropriate.

#### **Following Readmission to QEH on 20 October 2025 - fall on 10 November 2025 on Ward 513 – incident reported**

Mr McKinlay suffered a fall at 01.03 hours on 10 November 2025. The fall was unwitnessed. There was increased dependency on the ward at this time and staff were unable to provide 1:1 supervision on a consistent basis. Staff were conducting frequent checks instead. There were no staffing shortages on this shift however the dependency on the ward was significantly increased with two bays requiring cohort enhanced care as well as three additional patients in other bays requiring enhanced care. In addition, there were two patients, one requiring three nurses to provide supervision and the other patient requiring two nurses at all times. The situation was escalated to the senior nursing team and contact was made with an external Trust to request a registered mental health nurse to support the ward. Cover was provided on this date. We are aware of an increase in dependency of patients on this ward and a review is being undertaken by the Matron of the establishment level with a view to increasing this to meet the changes in patient cohort.

At the time Mr McKinlay fell, the staff were unable to provide 1:1 care to all of the patients, and they were cohorting and checking on patients as frequently as possible in order to mitigate the falls risk across multiple patients at the same time.

Mr McKinlay was reviewed immediately after the fall by the clinical team who recorded their findings and management plan at 01.30 hours. The incident was reported at 04.29 hours and automated emails were sent at the same time to the ward manager, Matron, consultant team for ward 513, falls team and clinical governance team.

On the morning of 10 November 2025 the falls team contacted the ward team confirming that they had reviewed the incident and downgraded the severity of the fall from moderate to low harm as there were no significant injuries noted following medical reviews. Again, the falls team reviewed the RADAR form, the clinical noting, observations recorded and assessments completed as well as reading the notes to understand the course of events and management plan going forward. At this stage it was recorded that Mr McKinlay continued on the end-of-life pathway and no further action was deemed necessary as per the medical team plan. It is noted that Mr McKinlay's daughter was made aware of the fall at 13.35 hours.

On 11 November 2025 the incident was reviewed by the clinical governance team and on 17 December 2025 the incident was closed by the ward manager following their local investigation into the fall and a Listen Learn Share form completed for all staff to reflect and review the circumstances surrounding the incident and learning identified which included ensuring that post fall observations are completed to time

and frequency as per the Trust standard and updating the post fall checklist (within the electronic daily care plan). The Matron is continuing to support a review of the current establishment given the changes in patient cohort resulting in higher numbers of dependent patients.

**Fall on 13 November 2025 at 01.51 hours on Ward 513 – incident reported**

Mr McKinlay had an unwitnessed fall at 01.51 hours on 13 November 2025. He had been identified as requiring enhanced care. During this shift, it had been challenging for the ward team to provide enhanced care to all those requiring it. There was significant resource focused on trying to mitigate patient harm/falls as far as possible, for example with the ongoing support of RMN's from an external organisation. The actions taken remained the same as following the previous fall three days earlier on 10 November, where patient dependency and staffing were escalated daily and regular contact was maintained with the external organisation in relation to the RMN support that they could provide. Where 1:1 care was not possible, the nursing team were checking patients as frequently as possible and providing 1:1 care where this was possible.

An incident report form was completed at 02.07 hours and automated emails were sent at the same time to the consultant team, ward manager, Matron, falls team and Clinical governance team

Mr McKinlay was reviewed by the medical team on the morning ward round where no specific injuries were identified following the fall. It is noted at 11.12 hours that Mr McKinlay's daughter was informed of the fall.

The same day the falls team confirmed via email to the ward team that again they had reviewed the incident and this fall did not show any clear signs of injury therefore was deemed to be low harm. As part of their review to determine this, they reviewed the falls assessments, the incident report and patient records to understand the course of events and outcome of the post fall reviews by nursing and medical staff, observations recorded and medical management plans.

On 17 November 2025 the ward manager completed their local investigation into the incident and completed a Listen Learn Share form highlighting the non-adherence to the falls procedure and reminding staff of the importance of ensuring that relevant assessments were completed and a recommendation that they all re-familiarise themselves with the Trust falls procedure. The specific learning identified included; that staff must familiarize themselves with the post fall retrieval procedure to ensure that they are retrieving patients from the floor using the correct methods, to ensure that documentation is thorough in order to record specifics about a patient fall including what footwear the patient was wearing, what exactly was discussed with the patient's next of kin, and also ensuring post fall observations are completed as per the Trust standards. This form was shared with the entire ward team. As mentioned above, the ward manager at the time continued to escalate the staffing and dependency levels and the senior nursing team continue to support a review of the overall establishment following a more consistent increase in patient dependency. In addition, staff have either attended or are being booked to attend falls training which covers all aspects of learning identified in each of the falls.

As set out above, there was a thorough review immediately following each incident, with actions being taken, where appropriate, to reduce the risk of similar incidents occurring.

**DETAILS OF FURTHER ACTION PROPOSED**

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We are assured that all of Mr McKinlay's falls have been appropriately and thoroughly reviewed at local ward level and by our corporate falls team and appropriate actions have been taken and/or are continuing. No further action is proposed.

**SIGNATURE**

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