NHS
Nottingham
University Hospitals
NHS Trust

Please ask for the Medical Director's Personal Assistant

[redacted]

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29 July 2026

[redacted]

STRICTLY CONFIDENTIAL
Miss Laurinder Bower
HM Area Coroner for Nottingham City and Nottinghamshire
HM Coroner's Court
The Council House, Market Square,
Nottingham NG1 2DT

Dear Miss Bower

Inquest of David Marriott: - Prevention of Future Death Report [PFDR] Response

I am writing in my capacity as Medical Director of Nottingham University Hospitals NHS Trust in response to the Prevention of Future Death Notice issued on 3 June 2026 following the death of Mr David Marriott.

May I begin with offering my sincerest condolences to David's family for their loss. I am deeply sorry for the missed opportunities and issues highlighted during the Inquest.

The concerns you have raised have been taken extremely seriously. Indeed, the Trust has agreed the resolution of recommendation 2 as a Patient Safety Priority for 2026/27.

Please find attached a commentary in response to the Prevention of Future Deaths Report issued to Nottingham University Hospitals NHS Trust following the Inquest into the death of David.

The actions either taken or planned in response to the learning from the Inquest are summarised below. The oversight of the delivery of these actions will be through our Quality and Safety Governance Committees with Executive oversight. Committees of our Board will receive a progress report.

I hope that this commentary provides assurance that we are committed to learning from this, and other incidents to significantly enhance the care of patients across the Trust.

Yours sincerely

[redacted]

Medical Director and Responsible Officer

[redacted]

Enc

Response to the concerns identified through the PFDR

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Concerns identified through the PFD

The coroner remained concerned that there were outstanding matters giving rise to concern that future deaths will occur, as follows:

1. Ensure all ED staff are familiar with the British Thoracic Society Guidelines (advising follow up chest x-rays for patients diagnosed with community acquired pneumonia in the presence of risk factors), and ensure the discharging doctors know how to arrange the same for patients being discharged from ED
2. A failure to have in place a system for reviewing radiology reports that arrive after the patient has been discharge from ED
3. Poor quality discharge summaries, a failure to have in place a system for quality assurance and a failure to share summaries with patients

1. **Ensure all ED staff are familiar with the British Thoracic Society Guidelines (advising follow up chest x-rays for patients diagnosed with community acquired pneumonia in the presence of risk factors), and ensure the discharging doctors know how to arrange the same for patients being discharged from ED**

After agreement with GP colleagues in the community interface working group, the confirmed local process for patients discharged from the Emergency Department with pneumonia is for them to see their GP approximately 6 weeks after discharge for a clinical review and a decision about the need for repeat imaging, in line with the British Thoracic Society (BTS) guidance. The clinical review is required for compliance with BTS guidelines.

Currently this process has only been agreed for ED discharged patients. Other clinical areas continue with their established local processes.

This process is detailed in the "Discharge Back to General Practice from the Emergency Department Guideline" at point 9 (Appendix 1 attached). The guidance has been recirculated to the Emergency Department Medical Team by email and WhatsApp and will be included within Emergency Department Induction sessions.

Information sharing with all established ED staff – new process update
Multimodal reminders have been sent to ED staff, both those currently working in the department and those working as regular locums, via email and our ED Updates communications group with a PDF of the guideline included as well as a hyperlink to the guideline in the email message.

Induction for new starters
The College Tutor has confirmed that the governance team cover GP discharge letters at induction in our "Hot Topics" session, and they will ensure that the specifics of the guidance around pneumonia follow-up are included as part of this (attached email Appendix 2).

Discharge Summary
The ED respiratory speciality interface collaborative team are designing a patient information leaflet to be given to those patients being discharged with pneumonia, based on BTS guidance. This will include patient information about the need to see the GP at 6 weeks for follow-up and why this matters. This leaflet will be completed in Draft Format by end of August 2026 and is expected for publication by October 2026 and can be shared if required.

Audit and Quality Assurance
A quarterly audit will be designed to review patients discharged from ED with pneumonia to:

- Quality-assure communication with patients and GPs about need for review at 6 weeks
- Review rates of follow-up X-rays in line with BTS guidance

The audit will be registered and live by September 2026, with first data collection planned to review 2026 Q3 (to follow departmental reminders/induction and information leaflet publication).

2. A failure to have in place a system for reviewing radiology reports that arrive after the patient has been discharge from ED

The Trust has acknowledged this system gap as one of its key Patient Safety Priorities for 2026-27 and as part of this has created a Patient Safety Priority Working Group to address it. This group is co-ordinated by corporate governance teams and consists of Emergency Medicine and Radiology senior clinicians, Trust digital leads, patient safety specialists and quality improvement support.

Given the scale of the challenges (average 791 daily attends to NUH ED in Q4), the workload is expected to be high and requires complex cross system working with integration into the current digital systems. Completing this work manually with current systems requires additional resource in significant excess of current capacity and is not deliverable or sustainable.

The working group intends to create a fully auditable, closed-loop workflow for identifying, reviewing, communicating, escalating, and tracking all imaging investigations requested from the Emergency Department, including studies reported after discharge and studies awaiting reporting, ensuring that every clinically significant imaging finding results in documented clinical review, patient communication where necessary, appropriate follow-up action, and confirmed case closure.

The specification is described (in Appendix 3) ED Discharge Imaging Results Follow-Up System
The purpose will be to ensure all imaging performed on patients discharged from ED is reviewed once final radiology reports are available, and that any significant findings are acted upon promptly.

This work is expected to take up to 18 months but will report monthly to Patient Safety Group. Phases include establishing the size/scope of need, review digital solutions and make any changes to the clinical systems, and address staffing resource requirements to deliver the process.

In the interim, the current Conserus and ZZZZ coding (used to indicate unexpected malignancy Appendix 5 4288 – Radiology Digital Pick-Up Codes) processes will cover high-risk conditions or potential cancer diagnoses (Appendix 4). Coupled with the actions to address concern 1, this will offer a balanced/mitigated medium-term risk.

This is preferred rather than creating a process in a rapid reactionary manner that would likely be inefficient and fragile with increased medium and long-term risks.

3. Poor quality discharge summaries, a failure to have in place a system for quality assurance and a failure to share summaries with patients

To support flow and optimise capacity, ED discharge summaries are primarily autogenerated and are then immediately e-posted to GPs in Nottingham City and Nottinghamshire, where this is possible. Discharge summaries are not provided to patients on paper or electronically, unless e-posting is not available in which case they are printed and posted by the administrative team after attendance.

Although there are advantages such as immediacy, cost saving and environmental profile, the Trust acknowledges the lack of written information for patients is a potential risk for some patients. The ED team would prefer to offer written discharge information to discharged patients to support aftercare and provide a record of attendance. Currently, staff do provide information leaflets specific to the relevant condition in many cases; for example, head injury advice leaflets. There is also consideration of using

QR codes and weblinks to provide alternate access to this information when feasible within the Trust digital development program.

Of note, results of blood tests and imaging from ED are already available to local practices to view through the shared electronic record system NCR (Nottingham Care Record), but it is accepted that additional narrative and patient information could strengthen the quality of communication.

In the interim, the Trust has already taken feedback and held discussions with GP colleagues to establish the preferred content of e-posted letters for patients discharged from the Emergency Department back to their care, leading to an agreed template. ED colleagues are completing pharmacy team feedback regarding discharged medication documentation to update the agreed template for improved medicines safety and this is expected to be completed by end July 2026.
Nervecentre will then require system updates to include a full clinician summary of attendance which will auto generated for those patients discharged directly from ED (as clinically appropriate).

Integration of digital systems remains complex but the digital team are exploring the possibility of automatically sending a copy of the ED discharge letter to the patient via Synertec (would enable electronic delivery +/- printed copy if not read electronically).

It is expected that this work will be completed in October 2026 and an update can be provided.

Education on Medical Documentation
The Trust now provides training on medical documentation as a fixed session in the annual Foundation Doctor Induction and in Resident Doctor teaching, including discharge summaries (applicable Trustwide, not just ED). The materials will be further reviewed and updated prior to the October 2026 delivery in response to this case and will emphasise the importance of robust follow up arrangements and what can reasonably be delivered by community colleagues and what needs to be delivered by NUH (current materials provided in Appendix 7). The Acute Deterioration Improvement Team will also provide an NUH intranet page with the resources.

Summary

The actions outlined above are intended to address the concerns identified in the Prevention of Future Deaths report.

I hope this response provides both you and the family reassurance of the Trust's commitment to learning from this case and to strengthening the safety and quality of care for our patients.

Appendices

Appendix 1 – 4276 Discharge to GP Guidance

Discharge to GP guideline.pdf

Appendix 2 – Doctor Induction

Re_ Doctor induction and GP discharge lette

Appendix 3 - Key Requirements of Closed Loop Systems for ED Imaging review:

- Automatically identify discharged ED patients with imaging investigations (X-ray, CT, MRI, Ultrasound).
- Generate a daily list of:
  - Imaging not reported at discharge.
  - Final reports issued after discharge.
  - Significant discrepancies between ED interpretation and radiology report.
- Ensure all flagged reports are reviewed by an appropriate clinician (e.g. ED consultant or nominated reviewer).
- Categorise findings by urgency and determine required actions.
- Facilitate follow-up actions, including:
  - Contacting patients.
  - Notifying GPs.
  - Arranging ED review, outpatient follow-up, or further investigations.
- Maintain a clear audit trail of:
  - Report availability.
  - Review date and reviewer.
  - Actions taken.
  - Communication attempts and outcomes.
- Track outstanding cases and automatically escalate overdue reviews or uncompleted actions.
- Support governance through regular monitoring and audit.

Appendix 4 - 4192 Management of Authorisation of Provisional Radiology Reports and Addenda to Authorised Reports

4192.pdf

Appendix 5 – 4288 Radiology Digital Pick-Up Codes

4288.pdf

Appendix 6 – Risk 12594 Radiology results ordered during an Emergency Department (ED) attendance, reported post discharge, will not be reviewed, acknowledged or actioned

This risk is drafted and waiting approval through the governance processes. Expected at specialty governance August 2026 for RMOG September 2026.

ID	Risk Type	Risk Category	There is a Risk of...	Care Group	Specialty	Risk Owner	Rating (current)	Risk level (current)	Risk Proximity	Adequacy of Controls	Planned Review Date	Stage
12594	Operational Risk (To be added to the Risk Register)	Quality	Radiology results ordered during an Emergency Department (ED) attendance, reported post discharge, will not be reviewed, acknowledged or actioned	Medicine (1)	Emergency Department (Adult)	Christopher Gough	20	Significant Risk			31/08/2026	New Risk, Under Development

Appendix 7 Trust training on medical documentation

Medical Documentation F1 f2

Dates for teaching are:

F1

20 October 2026 12:00-13:30 City Postgraduate Centre
27 October 2026 12:00-13:30 QMC Postgraduate Centre

F2

22 October 2026 13:00-14:00 QMC Postgraduate Centre
29 October 2026 13:00-14:00 City Postgraduate Centre

END***