Please ask for the Medical Director's Personal Assistant

[redacted]

16 July 2026

Nottingham University Hospitals NHS Trust

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Hucknall Road
Nottingham
NG5 1PB

[redacted]

PRIVATE & 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: Jennifer Susan Birch - 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 20 May following the sad death of Jennifer Susan Birch.

May I begin with offering my sincerest condolences to Jen'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. 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 Jen.

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

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. **(NUH) Failure to ensure an "inquiring mind" in satisfying the duty of candour**
2. **(ICB) Roll out of the Penicillin Allergy De-Labelling Pathway**

Response to the concerns identified through the PFDR

1. (NUH) Failure to ensure an "inquiring mind" in satisfying the duty of candour

Duty of Candour (DoC) is both a professional obligation for healthcare professionals, whenever there are any problems in care, and a statutory obligation for the Trust in the event of any incidents of significant harm.

Good practice in candour requires staff and the organisation to be open and honest with patients, families and the organisation when things go wrong. This professional duty is regularly discharged in clinical care when there are low or no harm events, (for example apologising for an extended wait, or that a procedure has caused a mild bruise).

Statutory Duty of Candour in accordance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires registered providers to ensure the timely reporting of incidents, sharing of facts with patients and families at the earliest opportunity, apologising when things go wrong and enabling effective review and organisational learning. This requires a sufficiently thorough and enquiring approach to understanding the facts, explaining what is known, identifying what remains uncertain, and ensuring that appropriate learning and action follow.

The Trust acknowledges that a culture of openness, timely reporting, and proactive evidence capture is fundamental to learning from patient safety events and improving outcomes.

The Trust fully recognises the coroner's concern that:

- Failure to submit a Datix report on the day of the event delayed escalation and appropriate response actions.

- This contributed to:

    - Failure to quarantine potentially faulty medical equipment
    - Failure to secure and download device data prior to overwrite/loss
    - Failure to retain some contemporaneous clinical documentation, including the anaesthetic chart

The Trust also acknowledges the coroner's wider observation that this issue is not isolated to one specific Department or incident but reflects a recurring, Trust-wide risk relating to the retention of evidence following clinical events.

Historic examples referenced, including retention of placentas, CTG traces, and medical device data, demonstrate that this is a systemic issue requiring a coordinated organisational response.

Other relevant cases of note:

- Placentas disposed of following neonatal harm; PFD report issued 2021 - Q Parker.
- Lost CTG traces – no specific case references.
- Cardiology medical devices not being retained/quarantined/inspected in a timely fashion leading to relevant data being overwritten or devices destroyed.

The Trust accepts that:

- There have been inconsistencies in the timely identification, preservation, and retention of critical evidence following incidents.
- These gaps have, in some cases, hindered investigations and delayed the establishment of factual findings.
- The underlying issue is both:

    - Cultural – absence of a consistently applied "forensic inquiring mind" at the point of care.
    - Systemic – lack of sufficiently embedded processes and prompts to ensure immediate evidence capture.

The Trust recognises that this is particularly high risk where medical devices are not networked or cloud-based, meaning that data may be lost when devices are powered down or reused.

The Trust has initiated a programme of system and culture improvement to address these concerns.

i. **Strengthening Policy Framework:**

Both the Medical Device Governance and Management Policy and Safety Events Reporting and Management Policy have been explicitly strengthened in relation to the immediate reporting of incidents and the retention and quarantine of devices and associated data. These documents are undergoing ratification through Trust governance channels prior to publication and are expected at Medical Devices Management Committee in September 2026. In the interim, the processes described in the policy are already being enacted when relevant incidents are reported.

ii. Introduction of new Standard Operating Procedures (SOPs)

Two new SOPs have been developed to provide clear, actionable guidance:

- Clinical user actions following medical device safety events (GGCM068).
- Medical Equipment Incident Management and Procurement actions following device safety events (CLCGP004).

These set out immediate steps to secure devices and preserve data for investigation, addressing the gap identified in this case. They also contain guidance on secure storage of such equipment and further testing or analysis processes, including engagement with the manufacturer for interrogation and checking. Governance sign off is expected in September 2026. These new policies will then be disseminated via PSG and MDMC routes to Care Groups for wider sharing. The delivery of these policies will be overseen by PSG and MDMC.

iii. Visual Prompts and Frontline Support

Posters and visual aids for clinical areas (including theatres) will be produced to reinforce when to act, what actions to take and reinforce why evidence preservation is critical, including who to contact for additional support if needed. These visual aids are intended to support real-time decision-making at the point of care. It is expected that that they will be available in October 2026 and can be shared with the coroner when available.

iv. Training and Workforce Development

A Trust-wide programme of enhanced training is being developed to:

- Improve understanding of when and how to report incidents promptly
- Promote a learning and candour culture
- Reinforce the importance of device quarantine and data preservation
- Embed expectations aligned to Duty of Candour and PSIRF principles
- Ensure all colleagues are aware of the need for prompt professional and statutory processes in the event of a patient safety event

Multiprofessional training is now available for colleagues to book and is running twice a month with high take-up such that additional capacity is being planned. There are also supporting resources and training videos on the Trust Intranet which have access tracking. Rollout will be monitored via the Duty of Candour Committee. Additional support will be offered to areas with relevant concerns or where there has been limited uptake. Key learning and signposting to resources and to dedicated training is now included in every new consultant induction.

v. Communication and Cultural Reinforcement

A formal communication plan will accompany the rollout of revised policies and SOPs. In the interim messaging is being disseminated via Care Groups to reinforce

immediate expectations and promote a proactive, questioning approach following incidents.

vi. **Clarity of expectation regarding individual professional standards and accountability for engagement with clinical governance in a learning and candour culture.**

QSOG will continue to ensure that individual accountability for engagement with governance processes is clearly reflected in policy and processes of induction, appraisal, revalidation, care group governance oversight, incident reporting and governance engagement (including FROE) and, where necessary, professional management frameworks.

Planned Improvements and Assurance

To ensure sustained improvement, the Trust is implementing the following:

- Reviewing opportunities to minimise reliance on non-networked devices so that device information is more immediately available.
- Strengthening digital data capture and retention mechanisms where possible.
- Auditing evidence retention practices, expected to occur at year 1 following policy launch.
- Monitoring compliance with incident reporting timeliness and exploring the rationale for any delays in reporting (accepting that some incidents may not be immediately recognisable).
- Progress reporting into Patient Safety Group and Quality governance structures, including a new digital quality platform for triangulated safety learning.
- Ensuring that individual accountability for engagement with governance processes is embedded via process and policy and that appraisal provides ongoing quality assurance.

The Trust acknowledges the concerns raised and accepts that inconsistent application of an inquiring, forensic mindset has led to failures in evidence capture and retention, impacting the quality of incident review on some occasions.

These actions are intended to ensure that the processes of discharging both professional and statutory Duty of Candour responses is not treated as a procedural requirement alone, but as an important opportunity to listen, investigate, explain openly, and identify learning to improve patient safety.

2. (ICB) Roll out of the Penicillin Allergy De-Labelling Pathway

The Trust notes that this recommendation was addressed to the Integrated Care Board (ICB). Penicillin Allergy De-labelling services are not currently commissioned within Nottingham City and Nottinghamshire.

There is increasing national recognition of the importance of penicillin allergy assessment and de-labelling programs as part of antimicrobial stewardship strategies. Evidence indicates that while approximately 10% of patients report a penicillin allergy, the vast majority are not truly allergic when formally assessed. Inaccurate penicillin allergy labels can result in the use of broader-spectrum or less effective antibiotics, which may contribute to poorer clinical outcomes, antimicrobial resistance, increased healthcare costs, and longer hospital stays.

National guidance from organisations including NHS England, UK Health Security Agency (UKHSA), the British Society for Allergy and Clinical Immunology (BSACI), and the National Institute for Health and Care Excellence (NICE) supports the accurate identification and management of drug allergies and promotes antimicrobial stewardship through the use of the most appropriate antibiotic therapy. Penicillin allergy de-labelling programs are increasingly recognised as an important component of this work.

Senior colleagues within NUH Allergy, Microbiology and Pharmacy Services are aware of the coroner's recommendation and are supportive of developments that would improve access to penicillin allergy assessment and de-labelling pathways for the local population. The Trust would welcome opportunities to work collaboratively with system partners, including the ICB, to explore the development of such services, subject to appropriate commissioning arrangements, workforce capacity and sustainable resourcing.

In the meantime, the Trust will continue to support good clinical practice through robust antimicrobial stewardship processes, specialist allergy advice where available, and ongoing education of clinical staff regarding the assessment and documentation of reported drug allergies.

In the interim, pharmacy and microbiology teams routinely support clinical teams with antimicrobial advice to offer antibiotic allergic patients the most effective antibiotic choices with the lowest potential risk of cross reactivity, side effects and resistance. When there are patients who have recurrent infections but uncertain allergy status, they can be individually referred to the allergy and immunology service.

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.