Northern Care Alliance
NHS Foundation Trust

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Salford
M6 8HD

[redacted]

7 August 2026

Ms Joanne Kearsley
HM Senior Coroner for Manchester North
Rochdale Coroner's Court
Floors 2 and 3
Newgate House
Rochdale
OL16 1AT

Dear Ms Kearsley,

Inquest into the death of Mr Barry Peter Joseph Davies

I am writing in response to your Regulation 28 report dated 12 June 2026 following the inquest into the death of Mr Barry Peter Joseph Davies.

I would like to express how deeply saddened I was to read of the circumstances surrounding Mr Davies' death. On behalf of the Trust, I would like to offer my sincere and heartfelt condolences to Mr Davies' family and loved ones. I recognise how difficult this time continues to be for them, and I want to assure them that their concerns have been heard and are being taken very seriously.

I am grateful to you for bringing these matters to my attention. The issues raised in your report are both important and concerning, and we are fully committed to learning from what has happened to help prevent similar occurrences in the future.

You raised two specific areas of concern:

1. That neurological observations were not carried out as frequently as they should have been prior to Mr Davies' deterioration being identified.
2. That neurological observations were discontinued on the evening of 22 October while Mr Davies was still awaiting a second CT scan.

Trust Response and Actions Taken

Evidence presented at the inquest by Dr [redacted], along with a subsequent statement from [redacted], Matron in the Emergency Department and Urgent Care Observation Unit, outlined the Trust's initial learning. Since that time, we have continued to reflect carefully and have taken further steps to strengthen patient safety and care.

We would like to provide assurance that a number of improvements have already been implemented, with further work ongoing:

1. A Neurological Observation Care Plan for head injuries has been developed to ensure early recognition of deterioration, with clear guidance on increasing observation frequency and escalation. This is currently undergoing final review and approval. This will be linked to the Head Injury Policy on the Trust Policy Hub and will be disseminated across the Trust by 30th August 2026, this will be supported by a communication plan and followed by an audit programme (described in more detail at point 13).

2. The Head Injury Policy and Neurological Observations Care Plan has been further updated to reflect that the decision to cease neurological observations must be an MDT approach and clearly documented in the clinical notes. The amended policy will be submitted for approval and distribution across the Trust by 30th August 2026.

3. A Head Injury Admission Proforma has been developed which supports an initial admission assessment of the patient's physiological observations and Glasgow Coma Scale, the neurosurgical plan including CT head findings and advice received from the neurosurgical team and a medication review including the use of anticoagulants and Haemostatics.

4. Local Standard Operating Procedure (SOP) - Urgent Care Observation Ward ("UCOU") Head Injury Admission has been drafted which will provide local guidance for the Oldham Hospital Emergency Department and UCOU, for adult patients (age >16) who have a head injury that requires admission from the emergency department to the UCOU. This will be approved via the Clinical Service Unit Assurance Meeting and then circulated to staff by 30th August 2026.

5. A single NCA NEWS policy (NCAUECCC002 – "Observation policy for Patients 16 years and over" was launched on 10th June 2026 replacing the previous separate versions applicable to Salford Royal NHS Foundation Trust and Pennine Acute Hospitals NHS Trust. The new policy includes additional guidance added to Neurological Observations – section 5.3 and will be included in the standard neurological observation training for nursing staff.

6. All registered nursing staff in the Emergency Departments across the NCA and Urgent Care Observation Unit at The Royal Oldham Hospital (the other sites do not have an observation unit) complete mandatory training in head injury and trauma care, including neurological observation requirements in line with NICE guidance. Current compliance is 100% for head injury training and 94% for Trauma Immediate Life Support training.

7. A poster has been developed to highlight the requirement for frequent neurological observations in patients with a head injury. It also emphasises that any decision to cease these observations must be clearly documented in accordance with Trust policy. The poster is now displayed across all clinical areas.

8. A programme of monthly audits has been introduced to monitor compliance with neurological observations and care plans, enabling early identification of any gaps and further training needs. There were 11 admissions from 1st June 2026 to 8th July 2026 for post head injury care. 3 sets of notes have been sent for scanning so could not be reviewed. Of the remaining 8 patients all had a head injury proforma and neurological care plan completed and 98% of neurological observations were completed on time. None of the 11 patients required escalation. Audit results and identified learning is being shared with the team at time of audit, for real time feedback and support.

9. In relation to the incident, reflective learning has been undertaken with the medical and nursing staff involved. Learning from the incident has been shared more widely through team safety huddles, including neurological observations, timely escalations and referral to haematology for patients presenting with head injury.

10. Regular “Learning from Datix” sessions are held within the department, where serious incidents are discussed openly to support continuous improvement. This case has shared within those sessions from June 2026 onwards.

11. Martha’s Rule was introduced in March 2026, supported by bespoke staff training and clear escalation policies. This ensures that patients and their families can raise concerns and request a further clinical review if they feel their condition is deteriorating or not being recognised. Patients on the ward are now routinely asked about changes in how they feel, with structured processes such the new NEWS policy in place to respond promptly to deterioration.

12. We are working closely with the radiology service to improve prioritisation of urgent CT scans, supported by the new head injury proforma that includes key safety prompts such as anticoagulation status.

13. Discussions are ongoing regarding the future development of Patientrack, the electronic patient observation and monitoring system used across Bury, Rochdale and Oldham hospitals. This includes exploring potential solutions for the digital recording of neurological observations. Further review and stakeholder engagement will take place as this work progresses.

We hope this provides assurance that we have carefully considered the findings from the inquest and have taken meaningful action. We remain committed to ensuring that the care we provide is safe, responsive, and centred on the needs of our patients and their families.

Once again, I would like to extend my deepest condolences to Mr Davies’ family. We are very sorry for their loss, and we will continue to learn from this tragic event to improve the care we provide to others.

Yours sincerely,

[redacted]
Chief Finance Officer and Deputy Chief Executive

Copy: Family of Mr Davies