Office of the Chief Executive Officer
[redacted]

NHS
Worcestershire
Acute Hospitals
NHS Trust

[redacted]

28/07/2026

Dear Mr Reid

Re Regulation 28 Report to Prevent Future Deaths

Please accept this letter in response to your Regulation 28 Report to Prevent Future Deaths received on the 25 * June 2026, following the inquest on the death of Jacqueline Frances O'Brien.

in your Regulation 28 report, you identified the following matters of concern relating to the Worcestershire Acute Hospitals NHS Trust (WAHT) and that you believe the trust have the power to take action to prevent future deaths.

•/ am concerned at how staff on the PDU at Worcestershire Royal Hospital failed:

a) For some 8 hours to carry out any checks or observations on a patient who was clearly becoming unwell; and

b) To follow up concerns raised by Mrs O'Brien's family about her condition on the afternoon / evening of her discharge.

I hove found, os a matter of fact that, hod they not so failed, they were bound to have noticed how unwell she was becoming and her transfer to Pershore would probably not hove taken place"

in response to your specific concern listed above we would like firstly to clarify that Mrs O'Bnen was on the discharge lounge prior to transfer to Pershore, we apologise for any misunderstanding that led you to believe it was PDU. Please find below the actions the trust have taken in relation to your concerns on her care before discharge:

An initial review has been undertaken and discussed in our Patient Safety incident Review Group (PSiRG) on 6th July 2026 and we have commissioned a case review to explore in more detail the events that day and what systems could be improved to aid our staff to care for patients safely and ensure records are accurate in a future scenario similar to this.

Our initial findings and immediate actions also include:

- We have identified that there is learning for our clinicians and nurses around documentation of their actions at the time of an event and their decision making as is expected by our governing bodies.
- We have identified and confirm that there were no documented observations in the discharge lounge, although the staff recall taking them but only on recording these on paper and not in the electronic patient record. We have reviewed the discharge lounge SOP as it lacked clarity around what we expect of our staff and how often observations should be recorded whilst patients are in the discharge lounge.

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- The Changes in the SOP include.
    - updated on total capacity of patients for the discharge lounge
    - updated on expectations for managing a deteriorating patient in the discharge lounge
        - in the event of a deterioration or medical emergency the patients consultant team will be contacted and arrangements made for the patient to be reviewed
        - The discharge lounge team will ensure that a full set of observations are taken and recorded on sunrise (electronic patient record} and a SBAR (Situation, Background, Assessment, Recommendation) approach for escalation is followed,
    - updated on exclusion criteria around patients who are confused and not suitable for the discharge lounge
- We can confirm there was no documentation of the family concerns in the patient's notes. Since the time of the case, Martha's Rule has been implemented across the trust, providing an alternative escalation pathway for both families and staff if there are concerns about a patient's condition, while it may not have been used in this specific case, it is now available to all patients, relatives and staff.
- We will review the more detailed case review for further system wide learning that can be implemented.

Please let me know if you require any further information.
Yours sincerely

[redacted]
Chief Executive Officer