

Please ask for the Medical Director's Personal Assistant

[Redacted]

12 October 2026

Medical Director's Office

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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

[Redacted]
www.nuh.nhs.uk

Dear Miss Bower

Inquest: Gloria Joan Monte
Prevention of Future Death Report [PFDR] Response

I am writing as Medical Director of Nottingham University Hospitals NHS Trust in response to the Prevention of Future Deaths Report issued on 17 August 2026 following the death of Gloria Joan Monte.

I would like to begin by offering my sincere condolences to Gloria's family. I am deeply sorry for the missed opportunities identified during the inquest.

The Trust has taken the Coroner's concerns extremely seriously. This response outlines the action taken and planned following the inquest. Delivery will be overseen through the Trust's quality and safety governance arrangements, with executive oversight and progress reported to the relevant Board committees. The Trust would be happy to provide a progress update of work ongoing at a suitable timepoint.

I hope this response provides assurance of our commitment to learning and improving patient safety across the Trust.

Yours sincerely

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Medical Director and Responsible Officer

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Concerns identified through the PFD

The Coroner identified the following outstanding concerns that could give rise to future deaths:

1. A failure to have in place a clear policy identifying the clinician responsible for acknowledging and actioning incidental findings arising from ED imaging reports
2. An over-reliance on Conserus™* alerts to identify and safety net incidental findings, and a lack of clarity of language in the Trust's Radiology Guidelines for the issuing of such an alert

***Conserus**™ system has been replaced - alerts now referred to as “*Radiology alerts*”

Response to the concerns identified through the PFDR

The Trust fully acknowledges the Coroner's concerns.

In response, the following actions are being taken:

1. A failure to have in place a clear policy identifying the clinician responsible for acknowledging and actioning incidental findings arising from ED imaging reports

NUH recognises that explicit clarity is required regarding clinician responsibility for managing incidental findings in ED, particularly those that may not be directly relevant to the reason for admission and may not be urgent.

Existing guidance from The British Medical Association states that responsibility for acting on a test result rests “*with the requesting clinician*”. GMC guidance requires doctors who arrange investigations to ensure that results are reviewed and acted upon appropriately. In practice, however, urgent treatment must take priority.

Generally most incidental findings do not need urgent action. If such findings are discovered then this should be progressed by the clinical team caring for the patient as with any other urgent test result.

If any non-urgent incidental finding may need actioning at a later stage, this should be clearly documented at the time that the information is received and handed over to the team subsequently assuming responsibility for the patient. NUH recommends that any such findings are recorded in both the clinical notes and in the electronic “live” Nervecentre working diagnosis list which transfers to the discharge summary letter, thus acting as a full problem list and “aide memoire”. The point of discharge then acts as a “check point” with the discharging clinician ensuring that all imaging results are reviewed prior to discharge.

All required actions should be completed by NUH colleagues at or before discharge unless there is a clinically compelling reason for completion in the community. For example, if osteoarthritis is noted incidentally and is symptomatic then it is appropriate to first see if symptoms improve with physiotherapy in the community, rather than NUH making premature secondary care referrals for possible surgery.

The discharge process is therefore the final safety check for completion of all outstanding actions, regardless of which clinician originally requested the test. The discharge letter is essential for safe continuity of care and must be accurate, contain the information needed by primary care, and be sent promptly, preferably electronically and at least within 24 hours.

Key principles are:

- Patients should understand their diagnosis, treatment plan and safety-netting advice before discharge.
- If GP review is required, the specific reason must be clearly documented and the request must be reasonable for general practice to undertake.
- GPs should not generally be asked to chase or act on investigations requested by the Trust.
- Where urgent specialist assessment is required, the Trust clinicians should use a direct specialist referral pathway rather than transferring responsibility to the GP. This includes suspected cancer, a rapidly progressive condition or a condition where harm may occur if the referral is delayed.
- Medication changes should be clearly communicated to both the patient and the GP in writing.

The table below provides a draft proposal towards formal agreement for discharge workflow responsibility for patients being discharged from the ED. It is provided to advise the Coroner of progress and reflects the commitment to achieve clarity regarding discharge workflow.

Example scenarios which were given by the Coroner have been addressed in full in the draft which is included as Appendix 1. At this stage the proposal remains **in draft** due to the requirement to progress both digital support and stakeholder feedback and formal governance processes and is subject to possible change in wording or detail dependent on these. The Trust estimated it will be 9-12 months until it is fully finalised and active.

Expectations for a Safe Discharge

To confirm expectations regarding discharge processes and communication, NUH is developing guidance on discharge expectations and discharge summaries. This will also reference learning from the PFD issued for Marriott dated 03.06.2026 with regard to discharge summary quality. This is complex work and is likely to take an estimated 9-12 months due to the challenges of integrating digital systems.

Documentation is already a dedicated module within the Foundation Year 1 and Foundation Year 2 teaching programmes and includes information on safe discharge workflows.

The Trust consider the following to be key to safe discharge, which will be reflected in the guidance:

- Reviewing and signing off all test results in Nervecentre and acting on them appropriately, including incidental findings.
- Ordering any required outpatient investigations through the responsible speciality team.
- Arranging hospital follow-up, including consultant upgrades and suspected-cancer referrals where indicated.
- Prescribing required discharge medication.
- Completing a GP discharge letter that summarises the presentation, diagnoses, treatment, clinical course, medication changes and follow-up plan.
- Communicating relevant information to the patient.

2. An over-reliance on [Conserus™] radiology alerts to identify and safety net incidental findings, and a lack of clarity of language in the Trust's Radiology Guidelines for the issuing of such an alert.

The Trust accepts the Coroner's concern that a radiology alert must not be relied upon as the sole mechanism for identifying, reviewing and acting on incidental findings. The clinician or clinical team responsible for the patient must review the full radiology report, document any clinically significant incidental findings, and ensure that appropriate follow-up is arranged. The absence of a radiology alert does not indicate that no action is required.

A radiology alert will not be generated for every abnormality described in a radiology report. It is intended as an additional safety mechanism for unexpected findings that meet the defined national alert criteria, rather than as a comprehensive notification of all abnormal results.

Expected abnormalities, findings already known to the clinical team, and abnormalities that do not meet the alert threshold may therefore appear in the authorised report without triggering an alert.

The responsible clinical team must consequently review the full report and act upon all clinically significant findings, whether an alert has been issued.

Revision of the Radiology Alert Standard Operating Procedure

The Radiology Alert Standard Operating Procedure has been revised to clarify which findings require an alert and to align the process with national professional guidance (Academy of Medical Royal Colleges (AoMRC) / Royal College of Radiologists (RCR) publication Recommendations on Alerts and Notification of Imaging Reports (2022).

. The revised NUH criteria (Appendix 2) include:

- critical findings requiring time-critical clinical management, expected or unexpected;
- imaging findings suggesting a new or probable new cancer, or a new or probable cancer recurrence, whether expected or unexpected;
- clinically significant changes or addenda to an earlier report where the change may affect patient management.

Where a finding is critical, the radiology reporter will also seek **direct verbal contact with the clinical team** so that action is not delayed by reliance on the electronic alert alone.

The revised guidance removes ambiguous terminology that could lead to inconsistent interpretation. It clarifies that the alert threshold for possible cancer applies to imaging findings that suggest a new or probable new cancer, rather than depending on whether a finding is described as “suspected”, “probable” or “suspicious”.

The examples used in the guidance are reworded to ensure that punctuation and wording do not create uncertainty about whether the threshold applies to a pulmonary nodule or another potentially malignant finding.

Incidental findings that do not meet the alert threshold

The Trust recognises that not every incidental or clinically significant finding will meet the threshold for a Radiology alert. This is necessary to avoid excessive alerting, which could reduce the effectiveness of the system. However, such findings must still be clearly described in the radiology report and reviewed by the responsible clinical team. For example, where an incidental pulmonary nodule is identified, the reporting clinician must clearly describe the finding and any recommendations in accordance with the relevant clinic-radiological guidance.

The responsible clinical team must then ensure that the recommendation is reviewed, discussed with the patient where appropriate, and converted into a documented referral, investigation or follow-up plan. If the patient is discharged, the finding and actions taken must also be included in the discharge letter.

Recording the finding in the clinical record or discharge summary alone does not constitute completion of the required action.

Communication and implementation

The revised Radiology Alert Standard Operating Procedure has been communicated Trust-wide to consultants, senior nursing staff, governance leads, advanced clinical practitioners and operational managers. Radiology drop-in sessions have also been offered to support staff with access to the system and with acknowledging and acting on alerts.

The guidance will be relaunched alongside the clarified patient-pathway and discharge guidance described in section 1. Communications will emphasise that:

- Radiology alerting is an additional safety mechanism and not a substitute for reviewing the complete radiology report;
- receipt and acknowledgement of an alert must be followed by documented clinical action;
- responsibility for action should be transferred explicitly when care passes between teams;
- outstanding incidental findings and follow-up arrangements must be checked at discharge.

The Trust will ensure that these expectations are incorporated into relevant induction, education and clinical governance communications, including communication to temporary and externally contracted radiology reporters who report NUH imaging.

Closed-loop assurance

ED will be supported to establish a Task and Finish group to explore a closed-loop process for imaging requested from the Emergency Department which has not been reported in full at the time of patient discharge. This is only applicable to patients discharged from the ED by ED. This process is necessary because not all imaging is fully reported prior to the patient leaving the department. Reporting requires a two-stage review process and the consultant authorisation. Every effort is taken to report ED and UEC scans fully whilst the patient is in the department. However, particularly out of hours, there may be a high volume of urgent scans and the available resource must be directed to the timely reporting of these. Some patients may also leave the department prior to completion of the imaging review (self-discharges).

This work is intended to identify reports issued or amended **after discharge**, ensure review by an appropriate clinician, record the action taken, track outstanding actions and escalate overdue cases.

Monitoring Implementation and Learning

Implementation and effectiveness will be monitored through the Patient Safety Group and the Learning from Deaths governance process. Assurance will include review of alert acknowledgement and action, incidents involving missed incidental findings, compliance with the revised guidance, and evidence that required referrals or follow-up investigations have been completed.

Summary

The actions described above are intended to address the concerns identified in the Prevention of Future Deaths Report following Ms Monte's death. This work is complex and ongoing. Timelines are interdependent and we would therefore like to offer the Coroner an update in 12 months, with an interim update at 6 months.

I hope this response reassures you and Gloria's family of the Trust's continued and full commitment to learning from this case and strengthening patient safety.

Appendix 1

Responsibility for discharge processes <i>DRAFT</i> Based on RCEM Discharge Summary Guidance https://rcem.ac.uk/best-practice/best-practice-discharge-to-general-practice/ At all times, patient care should be prioritised. If there are critical actions for clinical or operational safety, including writing a discharge summary, these should never be delayed by disputes between clinical teams regarding ownership – urgent safety tasks must be completed without delay by any available appropriate member of the care teams.	
ED-only management:	For patients managed without input from another specialty, the ED team is responsible for every element of safe discharge.
Specialist advice requested for management within ED:	Where a specialist provides limited generic advice to ED clinicians regarding management, without reviewing or accepting the individual patient, the ED team remains responsible for safe discharge. Examples of this are limited electronic advice (e.g. microbiology antibiotic advice), or non-urgent advice regarding an incidental finding. Any required specialist outpatient investigation or specialty follow-up must be arranged by the speciality team, unless an established electronic referral pathway exists for ED to use, such as a consultant-upgrade pathway. The clinician responsible for actioning follow up arrangements should be recorded in the notes.
Takeover of care Request for SDEC or admission to specialty ward	Pending review If the patient discharges themselves or is discharged by the ED team prior to the specialty accepting the referral and providing a clinical review, the responsibility for the discharge reverts in full to the ED team. Following review – decision by specialty to discharge from ED Where a specialty team in-reaches to review the patient and provides definitive specialist advice and or follow up, the specialist team is then responsible for the clinical decision making including the decision to discharge. The specialist team must clearly document in the clinical notes and arrange any follow up in specialty. ED remains responsible for completing the discharge summary but a full handover must occur. Following review – decision to admit after specialty review If a specialty confirms that the patient should be admitted for specialist in patient care and the patient is Fit For Ward (FFW), the accepting team then assumes responsibility for all medical decision-making from the point of acceptance. i.e. delays in bed capacity becoming available must not affect the specialty management and the patient in ED should receive equivalent care. It is accepted that a specialty will not be present in ED 24/7 and therefore the ED team will need to respond to clinical urgencies and liaise with the specialty team should the patient's clinical condition change. If the patient is discharged from ED by the specialty before being transferred to ward, the specialty team remains responsible for every element of safe discharge, including the discharge process and writing the summary. If the patient self-discharges from ED whilst waiting for a specialty bed then ED colleagues should contact the parent specialty team to ensure that they are made aware and can provide a definitive discharge summary. Digital solutions are being explored to support the immediate documentation and subsequent tasks.

	<i>The Inter-Speciality Working Guideline v1.2 confirms: “ED patients accepted for admission under a speciality become that team’s responsibility at the point of acceptance” (page 13).</i>
Expected” specialty patients	<i>“For patients seen as a “specialty expect” in ED—whether referred from the community, another hospital or through an agreed Trust fast-track process—and then discharged from ED, responsibility for every element of safe discharge lies with the specialty team.</i>
Liaison Psychiatry (DPM) reviews	<i>A current exception to agreements regarding discharge documentation is for those patients seen directly in ED by the liaison psychiatry team (DPM). The DPM service is employed by Nottinghamshire Healthcare NHS Trust (NHCT) and uses a separate IT system.</i> <i>The ED team will support outpatient prescribing and complete a brief GP discharge letter. This letter will not provide detailed specialist information but will record the liaison assessment and any key follow-up or medication arrangements provided by that team. A more detailed separate summary will be sent from the NHCT.</i>
Patients taking discharge against medical advice “self discharge”	<i>Responsibility for discharge workflow depends on which team holds clinical responsibility when the patient indicates that they intend to leave.</i> <i>However this can be challenging for specialty teams because they do not maintain continuous presence in the Emergency Department and may not be sighted of the discharge immediately or until informed by the ED. Digital solutions are being explored to support this process, for example creating a brief Self Discharge note in ED which can generate a task for the specialty team to provide further arrangements for outstanding tasks and follow up.</i> <i>Where the ED team remains responsible, it must manage the discharge. Where a speciality team has accepted the patient or assumed responsibility for their care, that team remains responsible even if the patient has not transferred from ED.</i> <i>The responsible clinician will be expected to follow the Discharge Against Clinical Advice Policy which has been rewritten and is currently going through governance processes. Self-discharge does not remove the Trust’s responsibility to complete and document all outstanding actions. This includes reviewing available results; acting on incidental findings; arranging required medication, referrals, investigations and follow-up; providing safety-netting advice and return precautions; and communicating relevant information to the GP and other services. Any results outstanding when the patient leaves must remain allocated to a named responsible team and be tracked to completion.</i>