SUMMARY REPORT

INDEPENDENT DESK TOP REVIEW

SERIOUS INCIDENT NUMBER 2023/5237

NOVEMBER 2025

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INTRODUCTION

NHS England commissioned an independent desk top review into the care and treatment received by the patient[1] whilst an inpatient in an NHS acute hospital, and the investigations undertaken. The patient had been admitted via the Emergency Department in 2021 to a medically fit for discharge ward; they died, as an inpatient, in December 2021.

An investigation panel was formed in order to undertake this independent desk top review, and is referred to, throughout the report, as 'the panel'. It comprised three individuals, two of whom are experienced incident investigators and one of whom is a clinical specialist of relevance to the patient's medical condition during their inpatient stay; all three panel members have substantial senior NHS experience.

The panel were provided with relevant documentation.

The Terms of Reference for this desk top review are laid out in Appendix I to this report.

[1] For the purposes of maintaining the individual's confidentiality, we refer throughout this report to 'the patient'.

TO UNDERTAKE A DESK TOP REVIEW AND CRITICALLY EXAMINE THE TRUST REPORT AND THE ICB COMMISSIONED INVESTIGATION INTO THE PATIENT'S CARE AND TREATMENT TO DETERMINE SUFFICIENCY OF ENQUIRY, WHETHER TERMS OF REFERENCE AND KEY LINES OF ENQUIRY WERE ADEQUATELY EXPLORED AND ADDRESSED.

The internal investigation report

1. The Trust investigation report was written in response to a formal complaint raised by the patient's family in March 2022. There is no completion date on the report, but it was sent to the family under a covering letter dated July 2023. The letter apologises for the delay in completing the investigation due to the police refusing permission for staff to be questioned until January 2023. It is important to note that there was some confusion for the panel regarding the sequencing of decisions made by the Trust, and therefore their intent when writing the complaint investigation. This was then clarified by the Trust. In brief, a meeting with the family was held in August 2022; a decision was then made around December 2022 that it would be advisable – given the Trust's troubled relationship with the family – for the ICB to undertake the investigation, and the ICB became the principal vehicle for responding to the family's concerns. The Trust ensured that the family's complaints were included in the subsequent Terms of Reference for the ICB investigation. However, the Trust sought to ensure regulatory compliance by addressing the family concerns and providing a summary of the evidence considered, without duplicating the ICB investigation. We return to this issue later in this section of the report.

2. The family's complaint letter comprised a detailed chronology of the patient's hospital stay from their perspective, and a number of questions.

Good practice

3. The investigation report is written in clear, concise language, which minimises medical terminology and is easy to read and understand.

Areas for improvement

4. The complaint investigation did not appear to be conducted fully in line with the Trust's complaint policy at the time (CP003):
    - A period of 180 days lapsed between the permission to proceed with speaking to staff (from the police) and issuing the report to the family. The Trust's gold standard is 25 days, but in complex cases, this can extend to a maximum of 60 days. The Trust subsequently clarified for the panel that they had told the family (in July 2022) that they would require 120 days because of the complexity of the complaint. However, they acknowledge that they did not

meet their deadline, and that communication with the family about this delay could have been improved.

- It is not clear from the documentation whether or not the family were offered a resolution meeting shortly after their complaint was received by the Trust. The Trust subsequently confirmed that a meeting with the family was held in August 2022.

- The panel acknowledges that responding to complaints and investigating incidents are two different – albeit complementary - frameworks, representing two ways in which a family's concerns can be explored. The panel considered that although the complaints investigation report may have been compliant with regulatory standards, it could have been improved in both tone and content, and its purpose clarified.

5. The report references that the Serious Incident Framework (SIF) 2015 supports the Trust decision not to report the alleged fall as a serious incident. Furthermore, the Trust subsequently clarified with the panel that their decision not to declare a serious incident was based in large part upon the findings of the first two post-mortem reports. The panel accepts the Trust's initial decision-making; however, when this did not satisfy the family, in our view there was scope for flexibility, and an incident could have been declared.

Managing complaints and investigations when there is police involvement.

6. The Trust were in a difficult position in relation to the police investigation and the instruction not to interview staff in response to any complaint/incident investigation. The panel has experience of this occurring in other Trusts and has concerns that this embargo – which can be inconsistently applied – interferes with a Trust's duty to provide safe care and improve services. Importantly, lengthy delays also cause unnecessary additional distress to grieving families. Our experience is that it is necessary for there to be liaison between the Trust executive team and senior leadership in the police in these situations, and this can resolve the situation more quickly.

The independent incident investigation

7. The Integrated Care Board (ICB) declared a serious incident and put the matter on Steis in March 2023; the family were then content for the independent investigation to proceed. The Trust supported the development of the Terms of Reference, drawing on the family's original complaint letter, and Terms of Reference were finalised the same month. Initially the police refused permission for the ICB investigator to interview staff, but this permission was then granted in May 2023. The final report is dated November 2023. The lead investigator was a senior clinician from the ICB, and specialist advice was provided by a Medical Consultant from another ICB.

Good practice

8. The report writer sought independent views where necessary.

9. The inclusion of the social care record – relevant to the events triggering the patient's admission to hospital – provided extremely helpful contextual information.

10. The panel's view is that the investigation was conducted in an exhaustive manner, drawing on all possible information. This is particularly commendable given the lengthy delays incurred since the family first made a written complaint to the Trust.

Areas for improvement

11. The panel identified three areas for consideration.

- **Terms of Reference (ToR)**. It is not easy to marry the very detailed ToR for the independent investigation with the report findings. Best practice suggests that the ToR should be very clearly identified in the body of the report.

- Our panel has reviewed the ToR and does not have concerns that any substantive questions were left unanswered. However, there were some questions where the answers were implied rather than directly answered. In other instances, summarised findings drawn out in the concluding section of the report were not always well evidenced in the body of the report. Following further clarification from the ICB report author, we accept that these areas of inquiry were fully addressed, albeit not clearly documented in the report.

- The panel recognises, however, that if the ToR are going to include numerous detailed questions, this can lead to a very fragmented set of findings that does not facilitate a clear narrative. The panel made a number of suggestions to improve clarity in this regard.

12. NOTE: none of these comments about the ToR detract from the thorough approach taken by the independent investigator.

13. **Behaviour and attitudes of staff, as questioned by the family**. There is no explanation in the report as to why some questions from the family were included in the ToR but not others. As we have already commented, some of the questions were not conducive to a learning approach for the investigation. However, our panel considered whether it would have been appropriate to include concerns from the family regarding behaviour and attitudes of staff as an area of inquiry. We also note that there is no reference or response to the family's concern that some staff on the ward may have lied in order to cover up an incident.

14. However, we do note that the investigator makes substantive comments regarding the breakdown in the relationship between the family and the Trust in the findings. It would have been helpful to have incorporated these comments into a section that was clearly labelled in such a way as to represent a response to the family's concerns regarding behaviour and attitudes. Following further clarification from the ICB report author in relation to this matter, we accept that addressing complaints regarding the behaviour and attitudes of staff is a highly sensitive area with the potential to further enflame the distress of all parties. Nevertheless, we remain of the view that it is possible to be supportive to all parties, and important to

demonstrate transparency. This need not necessarily involve highly detailed inquiry, but could, for example, include an explanation as to which questions posed by the family would be investigated and which would not and why not.

15. We also note that the investigator reported that two members of staff had been reported by the family to their regulatory professional bodies, and that both organisations had found that there was no case to answer. The panel suggests that it may have been helpful to reference the NHS Improvement guidance '*A Just Culture Guide: Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents*' which was in place at the time of the investigations, but has since been replaced by the '*Being Fair Tool*' (*https://www.england.nhs.uk/patient-safety/patient-safety-culture/being-fair-tool/*). These tools are used to aid decisions and to explain these to all parties when the investigation of an incident begins to suggest a concern about an individual staff member's actions.

BASED ON EVIDENCE PROVIDED BY THE TRUST AND ICB TO EVALUATE THE IMPLEMENTATION OF RECOMMENDATIONS AND ACTIONS FROM THE TRUST AND ICB INVESTIGATIONS

16. The Trust has been through substantial changes since the patient's death, including the launch of PSIRF[2] in April 2023, the appointment of a new Trust CEO in August 2023, and the move towards group working with another Trust in April 2024; this led to a full executive restructure and subsequent care group structure with a significant reorganisation of senior staff.

17. The investigation panel was provided with a copy of the Trust action plan, along with some evidence. We took the high level action plan provided, and added comments, both in terms of the evidence provided, and suggestions for further assurance.

18. Overall, it was clear to the panel that the Trust has worked hard to put in place new governance structures and updated policies and procedures that are comprehensive and relevant to the ICB investigation's recommendations. However, for a number of recommendations, assurance was not provided in relation to the impact that these updated structures and procedures may have had on aspects of patient care and family/carer experiences that are relevant to the findings of the investigation report.

[2] Patient Safety Incident Response Framework (https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/)

TO CROSS REFERENCE THE ABOVE INVESTIGATION REPORTS AGAINST THE CLINICAL RECORD, ORGANISATIONAL POLICIES AND NATIONAL GUIDANCE RELEVANT TO THE PATIENT'S CARE

Confirm the accuracy of the facts and chronology of the patient's care and treatment

19. The panel can confirm that the independent investigation report provides an accurate and detailed account of the facts and the chronology of the patient's care and treatment between September 2021 and December 2021. It is positive that the timeline incorporates the period of the patient's stay at the care home, immediately prior to her admission to hospital.

Determine the appropriateness of the treatment of the patient in the light of any identified health and social care needs, including a review of the medicine management during her inpatient stay, and identifying both areas of good practice and areas of concern.

20. The independent investigation concluded that the patient,
*'Had multiple co-morbidities and frailty making her susceptible to further health issues such as infection. The clinical consensus was that she had some underlying level of confusion as normal for her and that her confusion became worse by being in a different environment, having an infection and the impact of the fractured sternum. **** (the patient) did not comply easily with therapy intervention and along with her condition, would have become deconditioned in hospital, increasing her frail state.'*

21. The panel agree that this summary reflects the patient's state of health accurately.

Nutrition

22. The patient's nutritional intake was poorly assessed, monitored and managed.

23. On admission to hospital, she underwent a nutritional assessment. Key factors of Chronic Obstructive Pulmonary Disease (COPD) and suspected infection were not completed on the assessment, which meant that she was incorrectly categorised as moderate rather than high risk. This meant that she was not reviewed by a dietician, as the Trust policy requires for high-risk patients.

24. Although The patient's nutritional state was assessed daily, the possibility of infection continued to be missed.

25. Additionally, the patient was not weighed on admission, which is a requirement for all patients and of particular importance to those with frailty.

26. The lack of a recent baseline weight meant that potential weight loss could not be monitored accurately. Although intentional rounding[3] documentation indicated that drinks were regularly available at her bedside, food and fluid intake was often poorly recorded on the monitoring charts.

27. Given her poor nutritional intake, reduced mobility and prescribed opioid analgesia, the patient was at increased risk of constipation. The intentional rounding document records bowel movements but shows only one for the patient; a week later a consultant requested a per rectal examination and prescribed additional laxatives/suppositories. These actions appear not to have been undertaken.

28. The independent investigation identified all these shortcomings in relation to the patient's nutritional needs. There was limited exploration of why staff did not work in line with policy and expected practice, but recommendations were made in relation to practice, policy, auditing and training.

Acute kidney injury

29. The initial acute kidney injury (AKI) suffered by the patient was likely the result of dehydration and infection. The patient was in the high-risk group for AKI though given that she was frail, elderly and with a degree of pre-existing kidney dysfunction; but in all probability, given her other conditions, her kidney function was getting worse prior to the administration of the Alendronic acid[4] in hospital. The noted changes in kidney function are seen frequently in patients with infections and dehydration and are usually treated with supportive measures such as rehydration and antibiotics.

30. It is not clear as to the need to administer the alendronate during an acute illness. Typically, although biochemical changes are seen within days of administration, reduction in the fracture risk is not seen for many months so there was no imperative to act then. This treatment could have been deferred till later.

Pain management

31. The patient's pain appears to have been actively treated. She was prescribed regular buprenorphine patches on admission with regular analgesia along with oxycodone liquid as required for breakthrough cover. After 24 hours the co-codamol was stopped and replaced with regular paracetamol. Regular oxycodone was started a few days after admission and the dose adjusted. Also, codeine and MST[5] were used at various times. These changes in drugs and doses suggest that active pain management was taking place during the admission.

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[3] **Intentional rounding** is a structured process whereby nurses carry out regular checks on patients using a standard protocol to address such issues as positioning, skin, falls prevention, toileting, nutrition and hydration.

[4] Alendronic acit is a bisphosphonate medication used primarily to prevent and treat osteoporosis.

[5] Morphine sulphate tablets.

Review the adequacy of risk assessments and risk management, including the investigation findings regarding the knowledge and experience of staff in the use of equipment used during her inpatient stay.

Moving and handling

32. It is difficult from the clinical records alone to determine whether or not practice was in line with Trust policy and safe or unsafe in relation to the moving and handling of the patient. This is primarily because staff did not routinely record how she was moved but also because staff used differing terminology for equipment.

33. Taking into account the family's concern that the patient had been '*dropped*' by nursing staff, it was positive that a very thorough examination of policy, practice, training and equipment was undertaken as part of the independent investigation, including extensive interviews with clinical staff, consultation with manufacturers and a clinical expert in another hospital.

34. The independent investigation found a wide range of different practice and confusing use of differing terminology in relation to moving and handling.

35. On the day/night that it is alleged by the family that the patient was '*dropped*' the panel can see from clinical records and the two investigations, that two moving and handling events occurred where the movement did not go as planned.

36. Appropriate recommendations about moving and handling were made by the independent investigation.

Falls

37. The patient had presented at hospital following a fall and she had a history of falling. On admission, a nurse undertook a '*Falls Risk Assessment bundle'*. Although the assessment gave contradictory information about the patient's level of confusion, it correctly categorised her as at high risk of falling. At the time, an assessment of high risk automatically indicated that a '*Hoist and slide sheet'* was the only equipment which could be safely used for high-risk patients. This is contradictory to clinical assessment at the time. The panel also found it is contradictory to the manufacturer's guidance and the advice of the expert consulted in the independent investigation. This meant that whilst the use of the Sara Stedy[6] for the patient was clinically

[6] A device that enables a single person (staff member or caregiver) to assist patients to perform sit to stand transfers.

appropriate, there was a mismatch between actions pre-documented in a care plan following assessment and clinical assessment/opinion.

38. The independent investigation also noted that whilst ward audits were undertaken routinely, they did not pick up these discrepancies.

39. In line with the independent investigation the panel found no evidence that the patient's sternal fracture happened while she was in hospital. We agree that on the balance of probability, taking into account specialist opinion and post-mortem findings, this injury is likely to have occurred before hospital admission and become displaced through normal handling and care provision at the Trust.

40. Appropriate recommendations about falls prevention were made by the independent investigation.

NEWS2 and Sepsis Screening

41. The panel agree with the independent investigation that there were three aspects of practice in relation to caring for a potentially deteriorating patient that could have been improved in the patient's case.

42. Firstly, documentation was not always clear or consistent in relation to whether she had ''*new*' or '*worsening*' confusion. This is important as confusion is often caused by both infection and constipation. The independent investigator did not comment but the panel believes one of the factors contributing to this confusion may be the multiple different places where staff are required to comment on level of confusion. We note that the Trust is implementing a new electronic assessment of the fundamentals of nursing care which may assist in improving this situation.

43. Secondly the version of NEWS2[7] for people with COPD was appropriately used for the patient. The panel agree with the independent investigation that although the deteriorating patient policy was not always triggered when her NEWS2 score was elevated, she was reviewed each day by medical staff and more frequently when her condition deteriorated. The patient was correctly treated with appropriate antibiotics, one that covered chest and urine on admission and then a change in antibiotics once her condition changed. This meant her deteriorating condition was appropriately managed despite the policy not being triggered.

44. Thirdly The patient was admitted with a likely infection and later deteriorated. Despite suspecting a urine or chest infection, no urine sample (MSU) was ever sent for microbiology culture sensitivity (MC&S). The independent investigation found the rationale appeared to be

[7] NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. In December 2017, an updated version of NEWS, NEWS2 was published which is more specific for the use of people with COPD.

that samples are not taken because the ward was a discharge ward and this was not something they did. Later when the patient's condition significantly deteriorated an MSU was requested, and this was still not taken despite being requested by medical staff. This is not in line with the Infection and Sepsis Screening and Management Guideline for the Trust which states if sepsis is suspected treat as sepsis and *'all patients with suspected sepsis should have a chest x-ray and urine sample sent for MC&S at the earliest opportunity'.*

45. Appropriate recommendations about NEWS2 and sepsis screening were made by the independent investigation.

Examine the extent and quality of involvement of the patient and her family in developing and implementing her care plan.

46. It is important to acknowledge that there is a significant difference of view between the Trust and the family regarding the quality of the family involvement in her care – and by implication – the quality of the Trust's response as the family became concerned about her care on the ward.

47. When covid restrictions were tightened and visitors more restricted, it was positive that the ward phoned the patient's family as promised at the end of each shift to update them.

48. From an early stage it appears that the relationship became difficult between some of the ward staff and the family. The impact of Covid restrictions is not discussed in the reports, but it is our panel's view that these may have aggravated the deteriorating relationship between the ward and the family, as it was a highly anxiety-provoking time for both relatives and staff.

49. Following the patient's death, the family were apparently in contact with the Patient Advice and Liaison Service (PALS) raising concerns about the patient's care and visiting protocols. This was followed by formal and written complaints. Unfortunately, the relationship between the family and the Trust deteriorates still further.

50. The panel agrees with the independent investigator who suggests that a serious incident could have been declared on the Steis system, and that the family could have been handled more sensitively, with the Trust's executive team involved in decision making.

51. Our panel would go further and would suggest that when family members are not assured by the response of staff to their concerns, it is important to escalate matters in a timely fashion. Arranging a meeting with a Divisional Director or the Chief Medical Officer or Chief Nurse can sometimes enable families to feel properly heard and for any specific care concerns be addressed, if appropriate. Such meetings should ideally take place well before a family feels the need to make a complaint in writing.

52. In a similar vein, although we understand the Trust's reasoning regarding the NHS England 2015 serious incident criteria, in our view it would have been reasonable to respond to the family's continuing concerns by logging the patient's death as an alleged serious incident where acts or

omissions may have occurred that led to an avoidable death. This could then have been de-logged following an investigation should no failure in care have been identified.

Identify any gaps or omissions in the patient's care not adequately addressed within the two investigations.

53. The investigation panel did not identify any further gaps or omissions in the patient's care not already identified.

CONCLUSION

54. The investigation panel have independently reviewed the previous Trust and ICB commissioned investigations, the findings and recommendations. The panel concluded that there were a number of learning points identified from the Trust complaint investigation. The ICB investigation report was extremely detailed, with a number of good practice points identified.

55. The Trust leaders, in clarifying factual inaccuracies with this investigation panel, clearly demonstrated their own learning in relation to the handling of the complaint from the family; the panel supports their views as to what actions might have brought greater clarity to the situation.

56. The panel identified some learning points in relation to the ICB commissioned investigation report but, when reviewing the care provided to the patient, they did not identify gaps in care that had not already been picked up by the ICB report. Overall, the panel reached the same conclusions regarding the Trust's care of the patient as did the ICB investigation report: these conclusions were in line with best practice, national guidance and organisational policies.

57. The panel considered that there was learning for the Trust in terms of their handling of the family's concerns, both before and after the patient's death. The patient's admission to hospital took place during the pandemic, a time during which both staff and families were under considerable pressure. Nevertheless, the panel agreed with the ICB report investigator, that there were opportunities for a more sensitive approach from the Trust, including more timely intervention by clinical executive team members.

58. The Trust, in collaboration with the ICB, provided an updated action plan for the panel. It was clear that there had been a number of changes to governance structures and the executive team within the Trust since the patient's death. Considerable work has taken place to develop policies and procedures relevant to the ICB investigation findings. The panel suggest that there is now a need for the Trust to provide more assurance in relation to the embedding of new procedures and evidencing the positive impact that these have had. This assurance should be shared with and reviewed by the ICB.

RECOMMENDATIONS

59. The panel suggest that the Trust work with the police to agree protocols/communication channels, should such a situation occur in future. It may also be helpful for guidance to be provided in this regard at a national level, given that this difficulty – proceeding with an NHS complaint or internal investigation when there is a police investigation in process - occurs fairly regularly.

60. The panel suggest that there is now a need for the Trust to provide more assurance in relation to the embedding of new procedures in their action plan and evidencing the positive impact that these have had. This assurance should be shared with and reviewed by the ICB.

APPENDIX I: TERMS OF REFERENCE

Independent Desk Top Review into the Care and Treatment received by the patient whilst an inpatient in the NHS acute hospital, and the investigations undertaken.

Background to the Investigation

The patient was admitted via the Emergency Department in November 2021 to a medically fit for discharge ward. Later a fractured sternum was diagnosed, with accompanying chest pain. She was diagnosed with hospital acquired pneumonia, declining renal function and passed away on in December 2021.

Purpose of the Independent Investigation

- To independently review the robustness of the previous Trust and ICB commissioned investigations, the findings and the recommendations.
- To consider the quality of the care and treatment provided to the patient against best practice, national guidance, and organisational policies, based on a desk top review of relevant evidence already collated from the previous investigations.
- To independently review evidence for the implementation of the actions and recommendations from both the investigations.

Terms of Reference

To undertake a desk top review and critically examine the Trust report and the ICB commissioned investigation into the patient's care and treatment to determine sufficiency of enquiry, whether terms of reference and key lines of enquiry were adequately explored and addressed.

Based on evidence provided by the Trust and ICB to evaluate the implementation of recommendations and actions from the Trust and ICB investigations.

To cross reference the above investigation reports against the clinical record, organisational policies and national guidance relevant to the patient's care in order to:

- Confirm the accuracy of the facts and chronology of the patient's care and treatment.
- Determine the appropriateness of the treatment of the patient in the light of any identified health and social care needs, including a review of the medicine management during her inpatient stay, and identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including the investigation findings regarding the knowledge and experience of staff in the use of equipment used during her inpatient stay.
- Examine the extent and quality of involvement of the patient and her family in developing and implementing her care plan.

- To identify any gaps or omissions in the patient's care not adequately addressed within the two investigations.