University Hospitals Sussex
NHS Foundation Trust

28 April 2021

Our ref: [redacted]

Mrs Catherine Palmer
Assistant Coroner
West Sussex Coroner's Service
County Record Office
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West Sussex
PO19 1DD

University Hospitals Sussex NHS Foundation Trust
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Tel: [redacted] (Senior Executive Assistant)

Dear Mrs Palmer

The late Steven Charles Costello

Thank you for your Regulation 28 report dated 31 March 2021 and for your letter addressed to [redacted].

Firstly, I would like to convey my sincere condolences to Mr Costello's family and friends. We have contacted Mr Costello's mother with the offer of a meeting to discuss the learning from Mr Costello's inquest and to offer our support, condolences and sympathies in person.

As you know, we take every death extremely seriously and learning from inquests is a vital part of our ongoing improvements to patient safety in our hospitals. The following steps have been taken following the inquest into Mr Costello's death:

- Work is underway to update our Emergency Department template documentation and the revised documentation will be adopted by all of our Emergency Departments in our newly merged Trust. The new documentation is called Emergency Department Adult Mental Health Triage. It includes good clear guidelines that have been designed to help our Emergency Department staff to assess the risk of self harm, suicide, and the risk of harm to others when a patient is admitted to an Acute Hospital Emergency Department and is suffering from a mental health illness.
- The new documentation has a number of prompting questions which require the staff member caring for the patient to answer and space clearly labelled to scribe the answer; these questions have been designed with the help of our local mental health Trust, Sussex Partnership NHS Foundation Trust as the experts in the care of patients who are suffering from mental health illness. The documentation is colour coded with red, amber and green tick boxes (traffic light system) for an effective way to identify and to make the level of the risk in relation to an individual patient clear to all the staff in the Emergency Department. They will quickly be able to identify the level of risk from the patient's records.
- The new documentation then highlights the actions required depending on the level of risk identified, such as the frequency of observations required, advice on whether a patient should be specialed and the contact numbers to use if further support is required from the mental health team or the security team.

- The new documentation comes with an information chart to display on the wall in the Emergency Department with easy to read and easy to understand guidelines and a checklist to assist the Emergency Department staff, highlighting the important steps to consider and what to regularly reassess, such as whether the patient's regular medications have been prescribed so that they are available and can be administered whilst the patient is in the Emergency Department. This approach uses the mental health SMART assessment tool.
- We will audit the use of the new documentation to ensure there is a sustained improvement. We also intend to introduce this system of assessment and documentation to our Children's Emergency Department.

We are in contact with Sussex Partnership NHS Foundation Trust so that their expertise in the care of mental health patients is incorporated into our acute hospitals' systems of assessment and in order to provide extra support and training to all of our Emergency Department staff.

For additional reassurance, we are also arranging a peer review to focus on patient experience in our Emergency Departments so that we have an independent view to enable continuous improvements in the service we provide to our patients and their relatives and carers whilst in the Emergency Department.

To ensure the learning and improvements following Mr Costello's inquest are Trust wide with senior oversight, we have discussed the learning at our Trust Mortality Review meeting, in our Safety Huddles, and the Patient Safety Group meeting. Our joint Chief Nurse [redacted] recently visited the Emergency Department at the Princess Royal Hospital to meet the staff who were responsible for Mr Costello while he was there. [redacted] has confirmed how seriously the team have taken this tragic event, and she is assured that there is good senior oversight in the department and she has also been assured of the learning that has taken place following Mr Costello's death. The importance of good quality documentation, with regular updates in the records of patients suffering with mental health illnesses, while in our hospitals waiting for a mental health bed, has been emphasised in training to the teams.

Our documentation was not good enough for which I apologise. Mr Costello's nursing care records should have been updated every 2-3 hours to provide an accurate account of how he was and whether there were any changes which might have triggered a further mental health review. As set out above, I can assure you that the Emergency Department documentation has been updated so that it is consistent in its application across the newly merged Trust.

Thank you for bringing your concerns to our attention, I hope this response provides you with assurance of the actions we have taken to ensure improvement. Again, my heartfelt condolences go to Mr Costello's family.

Yours sincerely

[redacted]
Chief Medical Officer and Deputy Chief Executive