NHS
Mid and South Essex
NHS Foundation Trust

H.M Coroner's Office
Mr Sean Horstead
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

[redacted]

12 September 2023

Dear Mr Horstead

Regulation 28 Report- Mr Ronald Ashdown

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) sent to my predecessor [redacted] dated 18 July 2023. As you may be aware, I recently took up office as the new Chief Executive of Mid and South Essex NHS Trust following Hannah's departure last month.

I have been appraised of the Inquest findings in relation to Mr Ashdown, and your concerns contained within the PFDR report. I am deeply disappointed to note the failings in Mr Ashdown's care, and specifically the absence of basic personal care that we should all expect, especially for our most vulnerable patients including Mr Ashdown. I understand the facts of these failings to be extremely distressing for Mr Ashdown's family and I appreciate these concerns have, justifiably, led the Court to question whether we are meeting the basic hygiene needs of our patients.

I also note the issues identified regarding keeping accurate records, and the robustness of our investigations into care concerns; further, our ability to process and share information with our colleagues at the Local Authority. These are very important issues that we must get right.

I am sighted to the letters sent to you by my colleagues [redacted], Director of Nursing for Care Group 1, and [redacted], Associate Director for Safeguarding dated 21 June 2023 and 26 June 2023. I can assure you that Trust has taken further action since this correspondence, and specifically in response to the PFDR concerns.

Attached to this letter is a copy of our updated action plan setting out the steps we have taken and will take to ensure Mr Ashdown's experience is not repeated. Most actions are now complete, and those that are in progress will be complete by 30 September 2023.

Once all actions are completed, the plan will pass through our internal governance groups where the evidence supporting the actions will be thoroughly scrutinised prior to being formally 'signed off'. The senior leaders who attend these groups will insist on evidence-based assurance before authorising the plan to leave the governance process.

The action plan is underpinned by a focus on matron and ward manager leadership. We are planning to launch a ward manager supervisory role with linked key performance indicators later this month which will allow closer supervision and audit of the nursing care provided This will include monitoring the quality of the nursing care we provide. We are passionate about getting the basics right for our patients and this work feeds into an extensive Trust-wide plan to achieve this.

In our letter of 21 June 2023, we confirmed we were in the process of re-drafting our safeguarding policy. Attached to this letter is the amended policy which now has clear guidance on the management of section 42 safeguarding enquiries and how information should be shared between organisations. The policy makes clear that all evidence received by the Trust from external sources, including photographs, should be uploaded to Datix, our shared management software. The risk of omitting salient information for our investigations is inherently reduced.

As referenced in the letter of 21 June 2023, we contacted the Local Authority following the Inquest hearing and amended the findings of our internal response to the s42 investigation into to reflect the evidence given at the hearing. We shared a list of actions we had taken with them and, as per usual process, we awaited the final report.

The final report was due to be finalised on 30 August 2023, unfortunately at the time of writing it is not complete although we do of course expect the outcome to substantiate the safeguarding concerns raised. [redacted], Associate Director for Safeguarding continues to follow up with our Local Authority colleagues frequently and if any further action is required in light of this report this will of course be actioned as per the policy.

The amended safeguarding policy adds 'Appendix 2' which requires all s42 recommendations to be taken to our Executive Assurance Group. This will improve the robustness of governance for these investigations and allow for actions to feed into wider learning across all the Trust sites.

I am confident we are doing all we can to meet the personal care needs of our patients, and that we have systems and processes in place to monitor compliance with this standard. We will continue to strengthen our governance in relation to safeguarding practices and information sharing with external stakeholders; ensuring that all documentation is considered when completing our internal investigations.

The Trust appreciates the opportunity to learn from these events and is committed to improve the experience of our patients.

If you have any further concerns or you would like to discuss this case further, please do not hesitate to contact me.

Yours sincerely

[redacted]
Chief Executive
Mid and South Essex NHS Foundation Trust