Sheffield Health and Social Care
NHS Foundation Trust

11 January 2024

[redacted]
Director of Nursing, Professions & Quality
Sheffield Health & Social Care NHS Foundation Trust

Trust Headquarters
2nd Floor, Centre Court
Atlas Way
Sheffield
S4 7QQ
[redacted]

PRIVATE & CONFIDENTIAL
HM Assistant Coroner
Ms Alexandra Poutney
Medico Legal Centre
Watery Street
Sheffield
S3 7ES

Sent via email

Dear Madam

I am writing in response to the Regulation 28 Report to Prevent Future Deaths received following the inquest touching the death of Mr Gareth Etchells-Height, heard between 10 and 12 October 2023. SHSC is saddened by his death and have taken your concerns very seriously. We are confident we can learn from Gareth's death and improve the standards of care to mitigate as far as possible, similar circumstances happening again.

Your report raised four matters of concern, namely:

1. **Discharge and safety netting**

   The discharge report for Gareth did not contain details of his diagnosis or sufficient information about high-risk behaviours/triggers. The information within the discharge report was not fit for purpose and did not provide for an accurate or full handover to new healthcare professionals.

2. **Review of the medical notes**

   There was wholesale inconsistency in healthcare professionals reviewing medical notes before appointments, assessments, or handovers for Gareth. There was no written guidance on this issue and it led to Gareth being seen by healthcare professionals who did not have an up-to-date understanding of Gareth's condition and mental state.

3. **Failure to update risk assessment**

   There was a failure to update Gareth's risk assessment, which at the date of his death was last updated on 7 April 2022. Gareth's presentation had materially changed since 7 April 2022, and so the risk assessment effectively became redundant by virtue of the failure to update it. This impacted upon the ability of those caring for Gareth to identify and recognise changes in his behaviour that were triggers for acute mental health crisis or suicidal behaviours. In evidence it became apparent that the Trust did not have a system in place for routinely checking and updating the risk assessments.

4. **Record Keeping**

   There was a failure generally to keep proper records. It became clear as the evidence progressed that many of the record entries did not accurately or fully reflect the interactions with Gareth. There is no audit system in place to check the records.

I have outlined below the actions we will take to address each of these matters of concern.

1. Discharge and safety netting

We will complete and audit existing practice in relation to the completion of our discharge summaries and the process and documentation in support of safety netting. We will also review the format and function of our existing discharge templates. These tasks will be completed by the end of February 2024. Any deficiencies identified through these reviews and audits will be used to improve the discharge template in our new Electronic Patient Record System (RIO) and discharge planning practice in our clinical teams.

The new discharge template will be completed by the end of June 2024 and the launch of this will be supported by local best practice training by the Directorate Leadership Team. An audit of quality compliance will be incorporated into the existing cycle of biannual record keeping audits. Results from the audits will be reflected and acted through our local ward governance processes.

The importance of accurate and full completion of the medical discharge summaries will be included in the rotation training programme for medical staff.

2. Review of the medical notes

There is no established local guidance on how to prepare for a clinical review, appointment or handover with practice by and is largely being guided by local custom and practice and training. The Directorate Leadership Team will develop a Standard Operating Procedure covering ‘how to prepare for a clinical review` which will include what documentation should be read as part of the preparation for this by 30 April 2024.

On completion, the guide will be disseminated through local governance structures, via supervision and training arrangements to all clinical staff who utilise our electronic patient records and be available on our intranet.

3. Failure to update risk assessment

The individual practitioners involved in the review of care are aware of the importance of reviewing and updating risk assessments for individual clients. As we move to our new electronic patient record, this will give us opportunity to set review requirements as an automated reminder in addition to individual clinical judgement. This will be the Trust system to flagging the need for review of risk assessment documentation.

Our training currently focuses on the importance of reviewing and updating risk assessments, we will continue to deliver these key messages through supervision and monitor through clinical audit, recognising that clinical audit is a snapshot of overall caseloads. Audit will also take place through individual clinical supervision at team level as part of the record keeping requirements.

We will request regular reporting on clinical record keeping audits and monitor progress via our Directorate Leadership Teams into the Clinical Quality and Safety Group.

4. Record Keeping

I will refer back to my letter dated 3 November 2023 where we outlined the move to our new record system (RIO). The implementation of the system has been delayed for some services in the Trust, however, the functionality of RIO will bring about significant automated improvements in record keeping.

In addition to the positive impact of the electronic record implementation this year, we have also commissioned a new clinical record keeping policy and training, which aligned to the quality improvement programme we noted in our letter (3 November), will be rolled out to all staff teams. Built alongside this will be a robust audit programme which will include Trustwide clinical audit and team level audits through supervision and spot check audits as part of our Quality Assurance programme. We anticipate the policy will be completed by May 2024 and the training will commence roll out, alongside a clear communication plan from June 2024.

In the meantime, we will issue a Blue Light Learning Notice to all clinical teams and flag through our Trustwide cascade with the Executive Team the need to record accurately all patient facing interactions in a timely manner.

I trust that this addresses the issues raised to your satisfaction. These actions will be monitored and reported to the Executive Team and Trust Board. Please do not hesitate to contact us if you require any additional information regarding our actions.

May I again extend my sincere condolences to Mr Etchells-Height's family.

Yours sincerely

[redacted]
Director of Nursing, Professions & Quality