Kent and Medway
NHS and Social Care Partnership Trust

Dartford and Gravesham NHS
NHS Trust

Darent Valley Hospital
Darenth Wood Road
Dartford
Kent
DA2 8DA

[redacted]

Date: 24th May 2024

Patricia Harding
Senior Coroner Mid Kent and Medway

Re: Regulation 28 to Prevent Future Deaths Report- Response from Dartford and Gravesham NHS Trust and Kent and Medway NHS and Social Care Partnership

Dear Ma'am

Thank you for the Regulations 28 Report to Prevent Future Deaths dated 4 March 2024, in relating to the inquest touching on the death of Sarah Keen. We have considered the report carefully and in communication with Sarah's Mum and the supported living accommodation staff. The response provided has been written and agreed jointly between Dartford and Gravesham NHS Trust (DGT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT).

We have reflected on the concerns set out within your report and have outline below the steps that have been taken to address each point.

1. **The enhanced carer had not been told the reason that she was providing one to one care for Sarah.**

   Staff at DGT are required to give a full handover to the enhanced carer in line with the 'Enhanced Carer's Policy', which states: "A thorough handover of the patients' needs must be given by the nurse in charge of the ward. This must be documented within the patient's daily plan of care. The nurse in charge must also clearly explain the roles and responsibilities expected of the bank or agency staff member". Where we have not been able to reconcile differences in staff recollection of this information being shared, it was not documented in the patient's daily care plan.

   Action

   - Staff should record their handover to the enhanced care nurse to explain the risks to harm if they are not present.

- If a member of staff is required to escort a patient to their place of residence, the receiving person is informed and a handover between nursing staff and residence staff occurs. A note of this handover will be recorded in the patient record when the member of staff returns to the ward.

2. **The note left by the psychiatrist on the medical records did not contain any recommendations as to medication.**

   Whilst this is acknowledged by both Trusts, it is must be recognised it is not the sole responsibility of one clinician to share recommendations in regards to medication. There were missed opportunities by staff at DGT to gain an understanding of Sarah's medication quantities and management in the community, either by discussing this with Sarah (there was no record of discussion), speaking with the staff from supported accommodation, who visited Sarah at the hospital, or by communicating with colleagues at KMPT.

   DGT's 'Safe Issue of Discharge Prescriptions and Drugs (To Take Out - TTOs) Procedure' states that:
   Minimum of 14 days' supply for regular medicines (unless a specific course length has been prescribed). This gives the opportunity for the prescribing clinician to prescribe a 'required amount' rather than a standard amount of medication.

   Action

   - Once admitted to the ward, staff should seek to understand if patients admitted following overdose have any remaining medication at home, and if so, what quantity. This can be actioned by both members of the pharmacy team, medical and ward staff
   - If patients are living in supported or hostel accommodation, staff should make every effort to speak with supporting staff in relation to medication, and support available to the patient on discharge. This would preferably be done with the patient's consent, but if the risk to self-harm is significant, must be considered without consent of the patient.
   - The discharging clinician (both or either DGT and KMPT) should record if a reduced amount of medication should be prescribed because of risk of self-harm or overdose.
   - The discharge notification should indicate that a reduced amount of medication has been prescribed and the reason for this recorded.

3. **The note left by the psychiatrist on the medical records contained the abbreviation DSH.**

   Both organisations have acknowledged that abbreviations differ between Trusts and should be avoided, or spelled out in the first instance use, if it is to be used regularly through one record.

   Action

   1. A reminder to staff in both organisations has been circulated through Trust wide communications in regard to the use of abbreviations in patient records.
   2. Consider monthly interface meeting with agenda to include potential risk spots, developing shared learning and practice changes and building a culture of collaboration.
   3. DGT staff invited to participate in lessons learned discussions and join the KMPT Community of Practice for Liaison Psychiatry.

We have noted and welcomed a recent report from the Health Services Safety Investigation branch report: Patients at risk of self-harm: continuous observation and will work to implement the local learning they have identified to ensure staff have a shared understanding of the different roles and responsibilities of staff caring for patients.

Both of our Trusts would like to offer our sincere condolences to Sarah's family for their loss. We hope that our actions assure you and Sarah's family that we have reflected on your concerns and provided reassurance as to the changes made.

Yours sincerely,

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[redacted] – Deputy Chief Executive Officer-Dartford and Gravesham NHS Trust

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[redacted]- Chief Executive Officer- Kent and Medway NHS and Social Care Partnership Trust