Sheffield Health and Social Care
NHS Foundation Trust

TRUST HEADQUARTERS
Centre Court
Atlas Way
Sheffield
S4 7QQ
Tel: [redacted]

Our Ref: [redacted]

28th November 2024

PRIVATE & CONFIDENTIAL
Mrs Tanyka Rawden
HM Senior Coroner for South Yorkshire (West)
Medico Legal Centre
Watery Street
Sheffield
S3 7ES

Sent via email

Dear Mrs Rawden

I am writing in response to the Regulation 28 Report to Prevent Future Deaths received following the inquest relating to the deaths of Mr Bryan and Mrs Mary Andrews, heard between 1st and 2nd October 2024. SHSC is saddened by their deaths and have taken your concerns very seriously. We are confident we can learn from this and improve the standards of care to mitigate, as far as possible, similar circumstances happening again.

You raised concerns in relation to a lack of communication between services regarding the relationship between the diagnosis of epilepsy and the psychotic symptoms experienced by the person responsible for the deaths, which you outlined led to significant time lapses in treatment and the rejection of referrals.

In providing this response, we have worked collaboratively with colleagues from Sheffield Teaching Hospitals NHS Foundation Trust, in particular, with colleagues from the Neurology Department.

The Single Point of Access Service within SHSC is no longer in operation, following a transformation programme of our Urgent and Crisis Services. We have, therefore, not set out any actions in this response relating to how this service deals with referrals, given that referrals now go into each individual service. We are committed to taking the following actions:

1. When a service user, who is known to be receiving treatment from the Neurology Department, has a crisis assessment undertaken, an electronic copy of the crisis assessment and outcome/plan will be provided to the Neurology Department. This will ensure the appropriate specialists are aware of current concerns and risks relating to the service user.

2. Discharge summaries are electronically sent to GPs through our electronic patient record system. In this case, although the discharge summary was created on 9 May 2022, the day of discharge, it was further edited on 13 May 2022. It appears that because the discharge

summary remained in ‘draft’, it was not sent as a finalised document. We have included discharge summaries within our annual record keeping audits that we undertake within each service, to ensure the summaries are sent to GPs and are of a quality that meets our required standards.

3. We believe that strengthening relationships, specifically with the Neurology Department, will be beneficial for both organisations and for our shared care service users. We have committed to establishing a six-monthly shared learning forum to engender understanding of the interactions between neurological disorders, such as epilepsy and mental health problems.

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 & Mrs Andrews’s family.

Yours sincerely

[redacted]

[redacted]
Chief Executive

cc – [redacted], Chair
[redacted], Executive Director of Nursing, Professions & Quality