NHS
Northamptonshire Healthcare
NHS Foundation Trust

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Ref: PFD Shaun Hall (v1) 20250327
Date: 27 March 2025
Email: [redacted]

Mrs A Pember
Senior Coroner for Northamptonshire
The Guildhall
St Giles' Square
NORTHAMPTON
NN1 1DE

BY E-MAIL ONLY TO: [redacted]

Dear Mrs Pember

RE: Regulation 28: Report to Prevent Future Deaths – Shaun Kenny Hall

Thank you for your Report to Prevent Future Deaths ('Report') dated 30 January 2025 concerning the death of Shaun Kenny Hall on 14 December 2023. Before responding to the matters of concern you have included within your Report, I would like to express my condolences to Mr Hall's family and loved ones. We have carefully reflected on the circumstances surrounding Mr Hall's death and have identified the specific actions we will take .

Your Report expresses concern about the decision made by the Trust's Urgent Care and Assessment Team (UCAT) not to accept the referral made by NHS Northamptonshire Talking Therapies considering the information available to UCAT on 'escalating factors' and a statement made by Mr Hall that he 'would take his own life'. Your Report also expresses concern that the identity of the person receiving the referral for UCAT is unknown and that no notes were made of the referral. Responses to each point are taken in turn.

1. UCAT assessments on referral

In response to several national drivers and as part of our Trust's commitment to continuous improvement and learning from incidents, we are developing a range of new risk management processes, including policy updates, changes to risk management documentation and the commissioning of new training modules.

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Together, these new ways of working will strengthen our approach to the assessment of patients referred to the UCAT and all our crisis and community services. Our new approach will focus on risk formulations that seek to understand the drivers and context behind a service user's risks, which is a change from our previous risk processes that focused on indicating a level of risk such as 'low, medium or high'. These changes will provide staff and service users with a better understanding of an individual's fluctuating risks. As a result, there can be a focus on the development of co-produced safety plans with service users and carers. These safety plans will be owned by the service user and will be responsive to the individual's own needs and challenges when managing risk.

To support the transition to our new approach to risk formulation, we commissioned a training module from a leading, external provider that brings in national best practice and core skills around formulation and safety planning. To date we have trained more than 140 of our community staff and continue to roll this out across our teams. This represents 80% of the community workforce at this time.

2. The duty of candour of all staff

We take our legal duty to be open, honest, and transparent with the people who use our services extremely seriously. We expect all staff to comply with our 'Being Open / Duty of Candour Policy' and all clinical staff must complete a Duty of Candour training module. At the time of the incident, we arranged group supervision and spoke with members of the teams involved. We reiterated their responsibilities with regards to the duty of candour. The staff were able to participate in this reflective discussion acknowledging their responsibility and accountability. Additionally, we continue to monitor compliance with Duty of Candour training requirements via our mandatory training programme.

We have heard the concerns you raised and have elected to expand the use of call handling and recording systems within the Trust to our Crisis Services. We currently use a web-based call handling product within our response hub and have begun the process of extending the product into the UCAT services. By the end of July 2025, we anticipate that we will have trained all staff in the use of this product. This product will improve the accuracy of our record keeping and our ability to provide reflective interventions with staff.

3. Record keeping standards within the Trust

We expect all clinical staff to adhere to the record keeping standards of their respective professional body and to comply with our 'Health Records Management and Keeping Standards Policy'. We emphasised the importance of record keeping at the time of the incident to all staff in the UCAT team as a result of our initial learning. We continue to track the team's compliance with mandatory information governance training and have developed a new record keeping audit tool that ensures governance over the quality and content of records.

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Having further examined the circumstances surrounding Mr Hall's death, we have understood the need for a greater level of patient records visibility between UCAT and Talking Therapies staff. We have now enabled both UCAT and Talking Therapies staff to have full visibility of all records relating to the treatment of service users in their care.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]

[redacted]
Chief Executive
Northamptonshire Healthcare NHS Foundation Trust

Cc [redacted], Trust Chair
[redacted], Managing Director and Deputy Chief Executive
[redacted], Chief Operating Officer
[redacted], Chief Nurse
[redacted], Chief Medical Officer
[redacted], Director of Corporate Governance