East Kent
Hospitals University
NHS Foundation Trust

Chief Executives Office
Trust Offices
Kent & Canterbury Hospital
Ethelbert Road
Canterbury
Kent
CT1 3NG

North East Kent Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

By email only: kentandmedwaycoroners@kent.gov.uk;

13 August 2025

Dear Ma'am,

RE: East Kent University Hospitals NHS Foundation Trust (The "Trust") response to Regulation 28 received on 17June 2025 in relation to the case of Mr Upali METHTHANANDA.

I write in response to the Regulation 28 report the Trust received at the conclusion of the inquest into the death of Mr Meththananda. The Trust would like to extend their condolences once again to the family of Mr Meththananda.

The Trust wishes to reassure the coroner and the family that significant learning has taken place from this case and we are committed to improving our IT infrastructure to ensure patient safety is optimised

At the inquest you stated that you were concerned about the following:

I was concerned about the documentation as the inquest process had been hampered by the poor documentation and whilst I accepted that clinicians may have been providing care and not always documenting the care provided during this time the importance of documentation cannot be understated. However it was not just in the emergency setting where the clinical notes were lacking the clinical notes did not record key events and observations taken even in the period prior to his collapse. Clinical observations were not documented, meaning that trends were not available to treating clinicians and they would not have a full picture upon which to base any clinical decisions. Discussions between clinicians at other organisations were also not documented and forms used by the hospital for procedures were not used as required even by experienced clinicians. Whilst I heard some improvements had been made by the witness who presented the Trust's action plan I

remained concerned that the failure to document procedures and observations as well as advice given from third parties could lead to clinicians who take over care for a patient not having a full picture and leading to risks to patients in the future.

Our response to your concern and the actions the Trust has taken are explained below:

As part of our commitment to continually review and improve quality we recently undertook a trust wide audit supported by our Clinical Audit and Improvement Team of documentation across the organisation in all representative care settings. This highlighted a number of areas for improvement of both digital and written documentation which will be presented to our Operational Quality Governance Committee for support and communication across Care Groups. Following this ongoing documentation audits will be planned within Care Groups to monitor quality and progress in improvement.

Specifically, within the digital setting of documentation a number of actions have or will be completed:

- Gemba walks were conducted across the emergency and inpatient settings on the 3rd July and 1st August at Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate. A Gemba walk is a walk through of the clinical environment for senior leaders to review how processes are working in real time at the point of care to see for themselves where issues are arising. Actions are then set to follow up on these issues and improve the interface between patient care and note taking.

- Following feedback from the Gemba walks, additional IT Technical Team walks of the emergency and inpatient settings along with the Clinical IT Team will be undertaken in August to review the current IT hardware across settings. We will review provision, accessibility and reliability of hardware to ensure clinical teams have access to the right technology at the point of care to facilitate and encourage real-time documentation and recording of clinical parameters and observations.

- We are waiting for our Electronic Medical Record (EMR) supplier to install an improved trend charting which will allow clearer visibility of trends in specific observation parameters over time (i.e. 24 hours/12 hours). This should be installed by the end of September 2025.

- A communication plan will be actioned in August (importantly coinciding with the new intake of Resident Doctors in August as part of their training) to continue to highlight the importance of accurate and timely clinical documentation both in the inpatient and emergency settings but also in the discharge of patients to our clinical colleagues in the community through the Electronic Discharge Notification (EDN). A new EDN went live in April with significant improvements in clarity of documentation. The communications plan specifically addresses the use of 'copy and pasting' within the digital clinical notes.

- A trial will begin in the Surgical Teams at QEQM in August with the use of the 'Sunrise Mobile' (Sunrise™ - EKHUFT Electronic Medical Record (EMR)) application on a tablet device to assess whether this can facilitate more real-time documentation at the point of care to improve the quality of documentation in an acute setting by providing an easier and more portable hardware device over a computer on wheels.

- The digitisation of the surgical care plan documentation is being planned and along with this a review of Local Safety Standards for Invasive Procedures ("LocSSIP's") to plan digitisation. This will ensure they are always visible in the medical record and drive compliance with documentation through mandating where appropriate data entry.

We will continue to review these plans and re-audit to ensure that improvements are being made.

Yours sincerely

[redacted]

Chief Executive Officer