

Executive Medical Directors Office
Huddersfield Royal Infirmary
Acre Street
Huddersfield
HD3 3EA

25 September 2026

VIA EMAIL

Mr Crispin Oliver
HM Assistant Coroner
The West Yorkshire (Western) Division
Cater Building
1 Cater Street
Bradford
BD1 5AS

Dear Mr Oliver,

Re: Progress Update – Mr Myles Scriven

Further to our response dated 9 September 2025, I am writing to provide an update on the actions taken by Calderdale and Huddersfield NHS Foundation Trust following the inquest into the death of Mr Myles Scriven and the subsequent Prevention of Future Deaths Report.

The Trust remains committed to ensuring that the learning arising from Myles' death results in meaningful and sustainable improvements to the care of people with learning disabilities and those who may lack capacity to make decisions regarding their care and treatment.

Mental Capacity Act Implementation

A key area of focus identified through the inquest was the application and documentation of Mental Capacity Act (MCA) principles.

Since our original response, the Trust has undertaken a significant programme of education and awareness-raising in relation to the MCA and the care of patients with learning disabilities. This has included:

- Distribution of NHS England's guidance on implementation of the Mental Capacity Act in Acute Trusts for adults with a learning disability to all medical staff.
- Circulation of the updated British Medical Association MCA Ethics Toolkit.

- Education sessions delivered by the Trust's Nurse Consultant for Learning Disabilities to senior medical staff, operational teams and the Senior Nurse Forum.
- Promotion of the legal framework underpinning MCA decision making, including emphasis on the diagnostic test, causative nexus and the need for robust documentation of capacity assessments and best interests' decisions.

The educational programme has reinforced the key principles and requirements of the Mental Capacity Act, including the presumption of capacity unless there is evidence to the contrary, and the need to make all reasonable adjustments to support individuals to participate in decision making wherever possible. The programme has also emphasised the importance of recording capacity assessments using approved Trust documentation, ensuring that best interests decision making processes are appropriately undertaken and documented, and involving families, carers and advocates in decision making where appropriate to support person-centred care and compliance with legal requirements.

Mental Capacity Act Compliance

As detailed above, the Trust has continued to strengthen governance and assurance relating to the application of the Mental Capacity Act through:

- Review and revision of the Trust's Mental Capacity Act Policy, approved by the Safeguarding Committee in June 2026.
- Enhancement of MCA training materials to place greater emphasis on Principles 1 and 2, practical application, documentation standards and relevant case law.
- Introduction of regular case note audits to assess the quality and consistency of capacity assessments and best interests decision-making processes.
- Inclusion of Mental Capacity Act compliance measures within ward accreditation processes to provide ongoing assurance regarding implementation in clinical practice.

Audit and Assurance Activity

In line with the commitments made in our original response, the Trust has fully delivered and embedded a comprehensive Learning Disabilities Action Plan in response to the concerns highlighted by the inquest and the subsequent Prevention of Future Deaths Report. The programme has focused on improving workforce competence, strengthening governance and leadership oversight, enhancing the identification of patients with learning disabilities, and promoting the consistent application of the Mental Capacity Act. Robust audit and assurance processes have also been established to provide ongoing oversight and assurance regarding the quality and safety of care provided to patients with learning disabilities.

Significant developments include:

- Introduction of additional learning disability-specific elements within Structured Judgement Reviews undertaken as part of the Learning from Deaths process.

- Review of the 12 months preceding the death of every patient identified as having a learning disability to identify themes, opportunities for learning and examples of good practice.
- Ongoing oversight through the Learning Disabilities governance framework and Safeguarding Committee.

A recent Learning Disability Safeguarding Report presented to the Safeguarding Committee demonstrated the operation of enhanced governance arrangements, including:

- A dedicated learning disability incident dashboard.
- Review of all reported incidents involving patients with learning disabilities by the Nurse Consultant for Learning Disabilities.
- Divisional oversight through learning disability leads.
- Escalation of learning disability data through quality governance structures.

To provide independent assurance, the Trust commissioned Audit Yorkshire to review its arrangements and improvement programme relating to the care and support of patients with learning disabilities. The review, completed in August 2026, examined the care of 16 patients across 13 wards at both Calderdale Royal Hospital and Huddersfield Royal Infirmary and specifically considered identification processes, use of Hospital Passports, care planning, staff training, governance arrangements and oversight.

The audit provided the Trust with a Significant Assurance opinion and concluded that a comprehensive framework of policies, governance arrangements, staff training and patient-centred care tools is now in place to support patients with learning disabilities. The review also recognised significant improvement in the application of controls since the previous audit undertaken during November and December 2025.

The audit found that:

- 93.8% of patients reviewed had a completed VIP Hospital Passport uploaded to the Electronic Patient Record.
- Learning disability care plan compliance had improved significantly, achieving 98% in April 2026, 89.7% in May 2026 and 94.7% in June 2026.
- All patients reviewed had been correctly identified and flagged on the Electronic Patient Record.
- Governance arrangements through the Learning Disability Engagement Group, divisional improvement plans and reporting through the Clinical Assurance Group provided effective organisational oversight.
- Weekend quality audits and senior nurse reviews provided robust ward-level assurance regarding compliance with learning disability care requirements.

Whilst the audit concluded that the overall control environment was effective, a number of opportunities for further improvement were identified. These related primarily to ensuring consistent completion of the newly introduced daily Senior Nurse Learning Disability Checklist, improving the visibility of Hospital Passports at the bedside, strengthening compliance with patient-centred bedside information boards and enhancing digital reporting through the Trust's KP+ assurance system.

Improvement plans have been agreed and are being monitored through established governance arrangements.

The Trust Executive Board has also approved a comprehensive Learning Disability and Autism Strategy for 2026-2028. The strategy establishes a clear organisational commitment to reducing health inequalities, improving reasonable adjustments, strengthening co-production with people with lived experience, enhancing workforce capability and ensuring systematic monitoring of outcomes for people with learning disabilities and autistic people. The strategy includes development of a "Diamond Pathway" to support consistent care across inpatient and outpatient settings, expansion of learning disability and autism performance dashboards, enhancement of the reasonable adjustment digital infrastructure and ongoing partnership working with service users, families, carers and community organisations.

Training and Workforce Development

The Trust has significantly strengthened its learning disability training provision through a structured programme of education and awareness for all staff groups. Actions delivered include:

- Integration of learning disability awareness and care requirements into Trust induction and preceptorship programmes.
- Establishment of Learning Disability Champions within clinical areas to provide local support, guidance and education. Learning Disability Champions continue to be developed across clinical areas, and a structured programme of local champion leadership and workforce development has been incorporated into the Trust's Learning Disability and Autism Strategy.
- Prioritisation of Learning Disability Champions and senior nursing staff for Oliver McGowan Mandatory Training, completed by June 2026.
- Delivery of regular learning sessions, digital patient stories and targeted awareness campaigns to reinforce learning and maintain visibility of learning disability issues across the organisation.
- Enhanced supervision and development arrangements for matrons, together with weekly multidisciplinary discussions regarding patients with learning disabilities.

The Trust has continued implementation of the Oliver McGowan Mandatory Training on Learning Disability and Autism, with compliance continuing to improve and the organisation recognised regionally for strong performance and trajectory towards national expectations.

Patient Identification and Reasonable Adjustments

To support early recognition of patients with learning disabilities and ensure reasonable adjustments are consistently considered, the Trust has:

- Implemented electronic flagging of patients with learning disabilities on the Electronic Patient Record (EPR) system.

- Secured funding and implemented Robotic Process Automation to automate learning disability alerts and upload hospital passports.
- Introduced daily senior nurse reviews and multidisciplinary oversight processes to monitor compliance with care plans, reasonable adjustments and escalation requirements.

Governance and Leadership Oversight

The Trust has strengthened oversight arrangements through:

- Weekly Learning Disability multidisciplinary team meetings involving divisional matrons and senior clinical staff.
- Implementation of weekly nursing leadership audits across ward areas using a standardised audit methodology.
- Development of dedicated learning disability dashboards providing oversight of incidents, complaints, audit findings and patient experience data.
- Review and update of Learning Disability policies and standard operating procedures, including clarification of responsibilities at all organisational levels.

Measurable Outcomes and Evidence of Improvement

The Trust is now able to demonstrate measurable improvements arising from this programme of work:

- Hospital passports were present in all learning disability mortality reviews undertaken through the enhanced review process.
- Capacity assessments were completed in the majority of reviewed cases, with formal best interests' processes undertaken where required.
- Audits consistently demonstrated the use of person-centred approaches and appropriate learning disability terminology.
- Learning disability care plan compliance has improved following redesign of documentation, introduction of automated EPR prompts and enhanced staff training, with compliance monitored through established governance arrangements.
- Weekly nursing leadership audits are now fully embedded, providing regular and continuous assurance regarding staff understanding, care planning, application of reasonable adjustments and compliance with Trust policy.
- All incidents involving patients with learning disabilities are reviewed by the Nurse Consultant for Learning Disabilities, providing strengthened oversight and organisational learning.
- Learning disability patient safety, incident, complaint and patient experience information is now reported through dedicated dashboards and governance structures, enabling routine monitoring of trends and outcomes.

Collectively, these actions demonstrate that the Trust has not only completed the actions identified within its improvement plan but has established sustainable

systems of oversight, monitoring and assurance designed to deliver lasting improvements in the care, safety and experience of people with learning disabilities.

As detailed previously, the independent Audit Yorkshire review concluded that the Trust's arrangements for supporting patients with learning disabilities provide Significant Assurance, with robust compliance, patient identification and oversight processes in place.

Learning Disability Reviews and Mortality Oversight

The Trust has continued to strengthen mortality review processes with recent reviews demonstrating that hospital passports were present in all reviewed cases. Capacity assessments had been completed in the majority of cases reviewed and a formal best interests processes had been undertaken where appropriate. We are pleased to report that correct terminology and person-centred approaches were consistently evidenced in the audit.

The reviews have also enabled the Trust to identify a number of recurring learning themes and opportunities for improvement. These include the importance of effective multidisciplinary team working to support coordinated decision making and care delivery, the need for robust application and documentation of Mental Capacity Act assessments and best interests processes, the value of improved coordination across specialist care pathways, and the importance of enhanced oversight of patients with complex needs and multiple admissions to ensure continuity, timely intervention and proactive care planning.

Reducing Health Inequalities

The Trust has continued to monitor attendance patterns and outcomes for people with learning disabilities through a comprehensive "Was Not Brought" audit programme.

This work has enabled identification of:

- Patients at increased risk of disengagement from services.
- Areas requiring follow-up appointments and escalation.
- Opportunities for reasonable adjustments and targeted support.
- Service-specific trends requiring improvement action.

These findings are being used to inform clinical practice and reduce health inequalities experienced by this patient group.

The Trust has also identified further opportunities to improve access and outcomes for people with learning disabilities through its Health Equity programme. Current improvement work includes targeted initiatives within outpatient services and maternity care, expansion of learning disability metrics and dashboards, and enhanced monitoring of attendance patterns, outcomes and patient experience data

to support the reduction of health inequalities and improve equitable access to services.

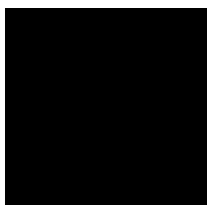
Ongoing Commitment

To provide additional assurance regarding delivery and sustainability of these improvements, oversight of this programme of work will be sponsored by a Non-Executive Director of the Trust. The Non-Executive Director will provide independent scrutiny and challenge through the Trust's governance framework, ensuring that the lessons arising from Myles Scriven's case continue to be embedded across the organisation. This oversight will help ensure that the actions taken remain aligned with the Trust's values, support continuous improvement in the care of people with learning disabilities, and reflect the needs and best interests of the patients, families and communities we serve.

While significant progress has been made, the Trust recognises that improving outcomes for people with learning disabilities requires ongoing vigilance, education and assurance. The Trust is continuing to maintain a strong focus on improving care and outcomes for people with learning disabilities through ongoing audit and assurance activity. This will include continued monitoring of compliance with Mental Capacity Act requirements, review of outcomes through mortality reviews and established governance processes, delivery of learning disability and Mental Capacity Act training programmes, and further work to strengthen the quality of documentation and evidence of clinical decision-making. The effectiveness of these improvements will be regularly evaluated through the Trust's quality assurance framework to ensure that learning is embedded into practice and results in sustained improvements in patient care and experience.

The Trust remains fully committed to ensuring that the lessons arising from Myles Scriven's death continue to influence and improve the care delivered to patients with learning disabilities across our organisation.

Yours sincerely



Executive Medical Director
Calderdale and Huddersfield NHS Foundation Trust