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20 October 2025

Dear HM Coroner

Re: Response relating to Regulation 28 Report into the death of Pamela Christine Brand

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18 June 2025, but received 5 August 2025 concerning the death of Mrs Pamela Brand on 2 April 2024.

In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mrs Brand's family and loved ones. West Suffolk Foundation Trust (WSFT) are keen to assure the family and HM Coroner that the concerns raised about Mrs Brand's care have been listened to and reflected upon.

Your Report specifically raises concerns that the hospital medical records lacked key detail regarding Mrs Brand's observations and rationale for clinical decision making. Specifically, that, although it had no bearing in Mrs Brand's case, for future patients, poor record-keeping may adversely impact on care and treatment.

Communication

We recognise that good record keeping is inextricably linked with communication. It is at the heart of everything we do, and we are working hard to improve both aspects of our care and specific projects are highlighted below.

A review undertaken before the global pandemic by NHS Improvement recognised that every 36 hours, a million contacts are made between patients and healthcare staff in the NHS and each of these is likely to generate further communication between staff. We recognise that failings in that communication are a common finding across the NHS. Good communication is about passing on clear and accurate information. However, it is also about expressing uncertainty; reading or 'sensing' situations; assessing others; understanding decisions; and, probing issues and concerns with the right priority.

We acknowledge that verbal communication which is then reflected in a patients' medical records is more complex than just words. The examples of when this goes wrong often

illustrate a combination of both human and system failures which we are working to address as discussed below. Unsafe communication can be as much down to the wrong tone of voice, dismissive body language, or a lack of information, or the presentation of items in a confusing order.

On a daily basis, our staff have to use a combination of human initiative, compassion and commitment to communicate effectively in the context of time pressures; practical constraints; and, conflicting demands in a busy and fast moving care environment. As a Trust, we are firm in our commitment to drive change and improve communication, led by the Chief Nurse and Medical Director.

Record Keeping

Record keeping has evolved over time and continues to do so. The single biggest change in recent times was when WSFT moved to a fully digitalised medical record in 2016. Since that time, we have continued to evolve the systems with clinical colleagues and other healthcare partners. However, record keeping is also a clinical skill that all our staff continue to refine and develop through their careers personally. There is no right or wrong clinical record. That is reflected in the absence of advice nationally on what makes a good record. What guidance exists is often general, non-specific and high level.

This is something NHS England recognised in March 2025, when it produced guidance for GPs on defining high quality patient records¹ when it said: -

“The meaning of what previously may have been described as a high-quality record has changed dramatically over the years. It is also important to remember that patient record systems contain a variety of clinical and non-clinical data from demographics, administrative, correspondence, clinical interactions, etc. It must also go further to capture context and in a modern-day general practice IT system, providing a conduit by which health professionals can communicate, interact, and record decisions. The quality of the record must be defined in the context for which it is used....”

Although aimed at GPs it is equally true for acute NHS Trusts like WSFT. NHSE’s guidance goes on to say that:-

“A high-quality record, therefore, needs to:

- be complete, accurate, relevant, accessible, and timely (CARAT)*
- enable the effective and reliable presentation of patient information from the patient’s records relating not just to the clinical data but other forms of data such as demographics, appointments, administrative, documentation, etc. ...”*

The GMC’s guidance on effective record keeping mirrors this, when it says a doctor “*must make sure that formal records of your work (including patients’ records) are clear, accurate, contemporaneous and legible*”²

The GMC guidance, with our emphasis added goes on to explain that one “**should take a proportionate approach to the level of detail** but patients’ records should usually include:

- a. relevant clinical findings*

¹ [NHS England » High quality patient records](#) version 1.1 dated 28.3.2025

² Good Medical practice, para 69... 2024

- b. drugs, investigations or treatments proposed, provided or prescribed*
- c. the information shared with patients*
- d. concerns or preferences expressed by the patient that might be relevant to their ongoing care, and whether these were addressed*
- e. information about any reasonable adjustments and communication support preferences*
- f. decisions made, actions agreed (including decisions to take no action) and when/whether decisions should be reviewed*
- g. who is creating the record and when”*

The MDU have defined effective record keeping and updated its guidance in August 2025³. Its guidance is that records should be: complete, contemporaneous, clear and legible, entered for the correct patient, avoid ambiguous abbreviations, avoid jokey comments, not tampered with, and checked. It also emphasises that there is a need for records to be proportionate.

Striking the balance between detail and proportionality is the key for the future and is something our Digital and Data team are working on. A current proposal is looking at trying to address the burden of documentation with an aim to review and justify the current level of documentation that nurses are expected to complete in a single shift.

Lastly, the NMC guidance on record keeping is set out in appendix 1 below.

Summary of Learning

At WSFT we have reflected on the national guidance above and incorporated that into the specific teaching we have provided staff at all levels. Drawing all this all together, please find listed below details of the action/projects/teaching undertaken with a focus on improving record keeping for future patients at WSFT. We sincerely hope this work goes some way to addressing this important national and local issue you have highlighted:

1. The Digital and Data team are currently drafting a proposal aimed at trying to address the burden of documentation, focusing on achieving the right balance of proportionality. The aim is to review and justify the current level of documentation that nurses are expected to complete in a single shift and streamline this. It cannot just be the case that we create more documentation, without addressing the human factors that prevent that. This is likely to be a larger piece of work and longer-term project running into next year.
2. The Trust Solicitor delivers a mixture of bespoke lectures on documentation to departments throughout the year, in addition to having a regular teaching slot delivering training to aspiring leaders as part of the Band 6 study programme x3 times per year. This lecture focuses on sharing learning from real life cases and experiences to put “*flesh on the bones of the general guidance above*” about documentation. It includes feedback from previous Coroner’s cases such as this one and explains a different perspective of how records are reviewed and used. A variation of this lecture has also been delivered nationally in November 2023 at the National Rheumatology conference.

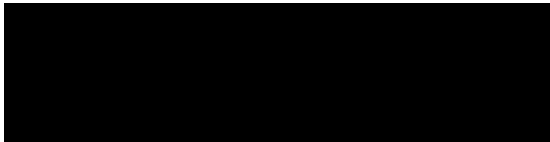
³ [Effective record-keeping - The MDU](#) 5 August 2025. Writing Clear, accurate and effective records supports clinical decision making and patient care

3. In the last 18 months there have been specific documentation projects aimed at driving up improvements in areas of:
 - a. Fluid balance measurement – we are attempting to resolve this through further education by the DPG and quality improvement projects.
 - b. Thromboprophylaxis - workflows are informed by the responsible committee and changes to system design are requested as required.
 - c. Discharge summaries – the associate medical director has refined the process for completing discharge summaries to improve timeliness and accuracy.
4. The deteriorating patient team have created a safety alert learning bulletin, a copy is at appendix 2, and carried out a safety walkabout with the aim of driving up standards in documentation and other areas. Point 5 of the bulletin emphasises the need for clear documentation.
5. In future there are plans for the junior doctors to conduct a VTE treatment audit with a focus on our documentation and what further steps are needed to drive this work forward into the future.

In addition to all of the above, in order to minimise harm and prevent documentation becoming a barrier to effective communication in future, WSFT will continue to work with all system partners, both to monitor and review performance as we look for new ways to address the difficulties of maintaining and achieving accurate record keeping.

Thank you for bringing this important patient safety issue to our attention. We hope this information assists to address your concerns and please do not hesitate to contact us should you need any further information.

Yours sincerely


Chief Executive

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App1 - NMC code for record keeping
App2 – Learning bulletin

Appendix 1 - NMC code for record keeping.

Fundamental record keeping principles

- Handwriting must be legible.
- All entries to records should be signed. In the case of written records, your name and job title should be printed alongside the first entry.
- All records should include the date and time of entry – in real-time, in chronological order and as close to the actual time as possible.
- Records should be accurate and recorded in such a way that the meaning is clear.
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.
- Use your professional judgement to decide what is relevant and what should be recorded.
- Should there be a need to alter/amend a record, the name and job title of the person making the alteration must be clearly identified, and both the original record and the amendment must be clearly signed and dated. All amendments made, and the original record, must be clear and auditable.
- Do not falsify any record.

Safety first alert

Is your patient wearing their prescribed anti-embolic stockings?

In the NHS, a VTE (venous Thromboembolism) risk assessment must be carried out for all admitted patients aged 16 and over to identify individuals at risk of developing blood clots.

Key points:

- The VTE risk assessment must be carried out on admission by the medical staff and repeated if the patient's clinical condition changes.
- The VTE assessment considers: an individual's VTE risk factors, appropriate thromboprophylaxis, determines contraindications, if anti-embolic stocking is to be applied to only one leg (this should be documented in the patient's notes) as well as the duration for monotherapy and the initial dose of thromboprophylaxis.

Patient risk factors for VTE include:

- Acute surgical admission with inflammatory or intra-abdominal condition
- Expected significant reduction in mobility
- Dehydration
- Obesity (BMI >30)
- One or more significant co morbidities

In view of the nature of acute hospital admissions, it is highly likely that the patient will have at least one of these risk factors.

NOTE: The use of anti-embolic stockings in medical patients is not mandatory

What can you do to help your patient?

1. Ensure your patient is wearing their anti-embolic stockings by checking during drug rounds (when they are typically signed for).
2. Daily removal of anti-embolic stockings for hygiene and skin checks (off for no longer than 30-minutes) (NICE Guidelines for VTE)
3. All healthcare staff reminding and/or assisting them to place them back on correctly
4. Educate the patient on the importance of wearing their anti-embolic stockings (you can give them the VTE leaflet).
5. If a patient understands the risks of not wearing their anti-embolic stockings and has capacity to refuse. Clearly document this on the patient's drug chart and patient record.

Correct VTE prophylaxis compliance can save lives!



Patient Safety

Putting you first

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