



6 February 2026

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Ms N J Mundy
HM Senior Coroner (South Yorkshire East)
The Coroners Court and Office
Crown Court Building
College Road
Doncaster
DN1 3HS

[REDACTED]
Executive Medical Director
Sheffield Health Partnership University
NHS Foundation Trust

Trust Headquarters
2nd Floor, Centre Court
Atlas Way
Sheffield
S4 7QQ

Email: [REDACTED]

Website: www.sheffieldpartnership.nhs.uk

Sent via email

Dear Ms Mundy

Prevention of Future Deaths Report issued following the Inquest touching the death of Mr Jason White - DoB 28/02/1969

I am writing in connection with the Prevention of Future Deaths Report issued following the above inquest that was heard before you between 20 December 2024 and 3 December 2025.

During the inquest, you identified areas of concern arising from the evidence presented, specifically:

1. The abrupt cessation of antipsychotic medication (Olanzapine) and the failure to follow the agreed management plan of daily monitoring.
2. The resulting increased risk of relapse, including the return of psychotic symptoms and deterioration in mental health.
3. The wider risk associated with abrupt cessation of medication without full assessment and appropriate monitoring, potentially exposing patients to serious deterioration in their mental wellbeing.

As a direct response to the learning from this case, we have strengthened our approach to monitoring service users following changes to antipsychotic medication. These improvements are already being implemented in practice, with full standardisation across all relevant services to be completed by 1 March 2026.

Specifically, any request for enhanced monitoring following medication changes is now formally logged and reviewed at the first daily multidisciplinary planning meeting (commonly referred to as the "huddle"). This ensures immediate visibility, shared clinical oversight, and timely decision-making. The process includes:

1. A structured clinical discussion to confirm the level of risk and the intensity of monitoring required. Where monitoring is required more than two to three times per week, referral to the Home Treatment Team is actively considered.
2. Clear allocation of responsibility to a named clinician, ensuring ownership and continuity of follow-up.
3. Where immediate follow-up cannot be undertaken, the requirement is formally recorded within the clinical diary system to ensure oversight and action by the duty team.

These arrangements are already operating within Community Mental Health Teams and are being embedded consistently across all teams to ensure a reliable and auditable approach.

In parallel, routine planned appointments with service users continue, providing ongoing clinical review, continuity of care and further opportunities for early identification of relapse or deterioration.

Collectively, these actions represent a significant strengthening of our systems for managing medication changes. They reinforce shared clinical responsibility, improve visibility of risk and ensure that monitoring arrangements are clear, proactive and responsive. Most importantly, they place patient safety at the forefront of care delivery following medication changes.

I hope this response provides assurance that the concerns identified during the inquest have been carefully considered and that meaningful, sustained improvements are underway.

Please do not hesitate to contact me should you require any further information.

On behalf of Sheffield Health Partnership University NHS Foundation Trust, I would like once again to extend our sincere condolences to Mr White's family.

Yours sincerely



Executive Medical Director

cc: , Chief Executive
NHS Sheffield Integrated Care Board