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NHS
Salford Care Organisation
Northern Care Alliance NHS Group

RECEIVED
23 APR 2018

If calling please ask for:
[redacted]

Salford Care Organisation
Salford Royal Hospital,
Stott Lane,
Salford
M6 8HD

Telephone: [redacted]
E-Mail: [redacted]

Our ref: PT/SJB

Date: 17th April 2018

Mr T Brennand
HM Coroner for Manchester West
H M Coroner's Court
Paderborn House
Civic Centre
Howell Croft North
Bolton
BL 1 1 QY

Dear Sir

Re: **James Sheffield – Response to Regulation 28 Report**

I write further to the Inquest into the death of Mr Sheffield which concluded on 31 January 2018. I acknowledge receipt of the Regulation 28 report that was subsequently issued on 12 April 2018 and note the concerns outlined.

As you are aware, following the conclusion of the Inquest, the Trust wrote to you on 2 February 2018 (a signed copy of the letter was subsequently dated 7 February 2018) in order to outline the prompt action that the Trust had already taken in response to the concerns which you raised at the Inquest.

I enclose a further copy of that letter, together with the enclosures, as the Trust's formal response to the Regulation 28 Report. I trust that the information provided assures you of the prompt action taken by the Trust to ensure that your concerns were swiftly addressed.

Please let me know if you require any further information.

Yours faithfully

[redacted]
Medical Director

HILL DICKINSON

HM Coroner for Manchester West
Mr T Brennand
H M Coroner's Court
Paderborn House
Civic Centre
Howell Croft North
Bolton
BL 1 1 QY

Your Ref:
Our Ref: 1093708.211.JT.JCRI
Doc Ref: 151239355.1
Date: 07 February 2018

[redacted]

Dear Sir

Re: **James Sheffield**

I write on behalf of my colleague, Joanna Crichton.

Further to the assurances given by [redacted] at the Inquest into the death of James Sheffield which concluded on Wednesday 31 January 2018, the Trust has already now implemented further changes to the ward to ward transfer document on its electronic patient record system in order to address the additional concern raised.

A screenshot of the updated document is attached showing the additional information which must be recorded on all transfers. A box requires confirmation that all essential equipment is available, checked and ready to use. The expectation therefore, is that equipment is set up upon transfer. In addition, if "yes is selected, details must be recorded. In the event that "no" is selected an explanation must be recorded to explain why this is the case. I can confirm that these changes are now live and have been fully implemented.

In order to accompany these changes, the Trust has circulated a safety alert to all staff to inform them of the changes to the EPR and the reasons for this. A copy of the alert is also attached to this email.

In the circumstances, it is clear that the duty to make a Regulation 28 report is no longer engaged since the Trust has already taken steps to put in place measures to prevent the recurrence of the risk identified.

Any Regulation 28 report in these circumstances would not have any practical effect and accordingly would not comply with the Chief Coroner 's Guidance Number 5 at Paragraph 5. The Coroner is also respectfully reminded of Paragraph 24 of that same guidance. It is a matter for the Trust to determine what the action should be in order to address the concern. The Trust has put in place additional changes to its ward to ward transfer documentation and process which it determines to be the most appropriate method of addressing the concern.

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The Trust takes patient safety seriously and wishes to ensure that lessons are learnt where possible. The Trust has taken on board the additional concern identified and has taken prompt action to address that concern. In the circumstances, a Regulation 28 report would be redundant.

Please do not hesitate to contact Joanna Crichton or I should you wish to discuss this?

Yours sincerely

JACrichton

pp [redacted]
Partner
Hill Dickinson LLP