NHS
Norfolk and Suffolk
NHS Foundation Trust

Our Ref. ML/AL
Your Ref.

LBHF CORONERS & MORTUARY

11 FEB 2019

Trust Management
1st Floor Admin
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich
NR6 5BE

**Private and Confidential**
Dr Séan Cummings
Assistant Coroner
Area of London (Western Area)
25 Bagleys Lane
Fulham
SW6 2QA

8 February 2019

Dear Mr Cummings

**Re: Mr Henry Curtis-Williams**

I write in response to your report dated 19 December 2018. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the death of Mr Henry Curtis-Williams.

You raise a number of areas of concern which I respond to in order:

**Recording of contemporaneous notes**

You identified concern that there was a culture of not recording contemporaneous notes, most obviously related to the recording of the presence or absence of suicidal ideation. I agree it is critical that the service user's health record demonstrates the care provided in meeting their individual need. In Henry's case, he had been admitted following a period of experiencing suicidal thoughts, with it reasonable to expect these symptoms were checked during interactions, then to be followed up with the details of discussion recorded in the health record.

The Trust's Health record policy provides guidance that entries should be made into the health record as soon as possible from the time of the event. The policy further outlines the requirement of clinical judgement to determine what information to record. To support staff, the Trust will be using Henry's case in the provision of learning via our patient safety newsletter and through the range of practice education teams and staff receive. Linked to this, under the leadership of the Medical Director, the Trust is commencing a programme of work to examine the barriers to using 'clinical curiosity' and develop the skills and frameworks for staff to ensure this critical aspect of care is consistently applied.

**Discharge**

You identified concern that Henry was discharged by a junior doctor without prior reference to a Consultant or senior colleague. Discharge from hospital can represent a period of uncertainty and risk for the service user. Therefore, it is right to observe that such decisions must be made using members of the multi-disciplinary team who have the required knowledge and skills to support a safe and supportive discharge. Following receipt of your report the Trust has completed an audit to examine the current practice applied. Reviewing eighty-two records, from discharges completed in August and September 2018, the audit confirmed 96% had evidence within the health record that a senior doctor or Consultant had been part of the decision of discharge. To strengthen this, the Medical Director has

ued learning to Consultant Psychiatrists and teaching will be provided to junior doctors as part of their induction to the Trust.

**Communication between staff**

You observed that communication between staff was very informal with no record of important messages relayed. You referenced that information did not reach the ward round.

Communication is a vital component in maintaining safe and effective care. The Trust uses systems such as an electronic patient record to document patient care, as well as frameworks to handover information (Situation, Background, Assessment, and Recommendation (SBAR)). However, this tragic event highlights the human aspect of receiving information and ensuring it is fed into these communication structures.

There is no current single evidence-based tool which can be implemented to eliminate this potential. However, shared understanding amongst staff of the processes of receiving information is critical to reduce variance. Following some recent learning, the Trust had issued an internal alert to all our inpatient wards directing reflection on the points where information is received from differing sources eg service users, families and carers and whether there is a shared process or understanding of how to ensure that information is captured. Where there may not be a shared understanding the ward will work to address this. Feedback from this alert is being received currently which will then be shared across the wards to promote wider learning.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Antek Lejk
Chief Executive