NHS
Greater Manchester
Mental Health
NHS Foundation Trust

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PRIVATE & CONFIDENTIAL

HM Assistant Coroner Kevin McLoughlin
HM Coroner Court
Paderborn House
Howell Croft North
Bolton
BL1 1QY

Dear Mr McLoughlin

Re: Inquest into Mr William Lound - deceased

I am responding to the Regulation 28 issued to the Trust on 19 January 2018 following the death of Mr William Lound.

In your letter to the Trust you have raised a number of concerns identified for Greater Manchester Mental Health NHS Foundation Trust. I have highlighted the concerns you have raised for the Trust and provided the Trust's response below.

The care and treatment provided to Mr LA (Mr Lound's attacker) in 2015/16 whilst in the community was fragmented, lacked continuity and an appropriate management strategy. Instead of being treated by the same team of psychiatric clinicians in 2015, he was admitted to four different psychiatric wards during 2014. The consultants involved in his treatment did not confer sufficient to produce a clear management plan.

As you aware following our Medical Director's statemented evidence provided at Mr Lound's inquest, one element of medical oversight identified by the NHSE Independent NICHE investigation was the high rate of consultant vacancies and use of locum cover and the impact of this on continuity and quality of care to Mr Lound's attacker. Since the acquisition by Greater Manchester West Mental Health NHS Foundation Trust (now GMMH) of Greater Manchester Mental Health Trust and the commencement of the transformational work in Manchester there has been an active drive to recruit substantive staff in all areas with particular emphasis on inpatient wards. Since the acquisition, we can now confirm that all substantive consultant appointments across in-patient areas within our Manchester services have now been filled.

There is on-going work to develop a consistent divisional model of service delivery in Manchester. This is designed so that there is enhanced continuity of care for service users by simplifying and rationalising the service model. We have invested in clinical and operational leadership across Manchester to drive forward this consistent clinical model. The operational and clinical leadership of our Manchester service follows the divisional structure e.g. Lead Consultant for North Manchester Community Mental Health Team and Home-based Treatment Team with a Service Manager for North Community and Urgent Care.

Together they chair the North Community Senior Leadership Team. There is a similar structure in in-patient services with a Lead Consultant and Inpatient Service Manager for Park House. Our services are clinically led and operationally partnered. This structure provides enhanced medical leadership, closer supervision of consultants including any locum appointments and active recruitment into vacancies are all a priority of these leadership posts.

As part of the new organisation (GMMH) we now have a designated Strategic Lead for Patient Flow who has reviewed the Standard Operating Procedure for managing admissions and discharges. This role includes the following key elements:

- To monitor the use of Adult, Older Adult and PICU inpatient beds and ensure that there are robust bed management systems and process in place across Greater Manchester Mental Health Inpatient services. That there are clear policies and procedures, including bed management meetings to monitor current inpatient progress, discharge planning and transfers of care when clinically appropriate.

- To reduce the use of Out of Area Placements and create capacity within the Trust Inpatient Services, to enable service users requiring Inpatient care to be admitted as close to home as possible. Consistent with their needs, recovery focused and reduce the possibility of service users being transferred between units and teams unless it clinically indicated or in an emergency. We are aware that Out of Area Placements have a significant impact on continuity of care and the reduction of Out of Area Placements is a key work stream for the trust.

- To attend professionals meetings/case conferences for complex cases as required, to ensure all aspects of such individuals care have been considered by all relevant professionals and external organisations involved in their care and treatment, such as Consultant, Care Coordinator, Forensic specialist, Learning difficulty services, GMP, Probation, Housing etc

- Lead on a Trust Wide bed management meeting that focuses on developments, new initiatives, monitors incidents, and promotes an environment for continuous shared learning and good practise across all in-patient services.

The Patient Flow Team have responsibility to identify high-risk individuals where the concern regarding continuity of care is heightened and endeavour to admit to an appropriate consultant with previous knowledge of the patient if this is possible and clinically appropriate. It is the role of the Patient Flow team to minimise multiple team involvement and to attempt to ensure that high-risk patients will be admitted under the same team if this is possible.

The trust is reviewing all the care-planning procedures in the light of the lessons learned from this case to ensure that there is continuity of care and a consistent management plan with particular emphasis on high-risk individuals. Discharge procedures have also been reviewed and high-risk patients should not be discharged without a completed formal discharge care plan and risk assessment with consultant oversight. The discharge care plans will include consideration of the risk of disengagement and non-compliance and the response to these.

GMMH has ensured careful consideration is being given to the management of service users who go AWOL and the risk assessment process to be carried out prior to a multidisciplinary team discharging them.

A variety of incidents should have alerted the clinicians and others involved in his management to the need for a multi-disciplinary case conference or a reassessment by an experienced Forensic Psychiatrist. Neither of these took place and in consequence warning signs of impending violence went unrecognised. Examples included being found by the Police in a public place in possession of a bladed article whilst under the influence of some substance and admitting he was hearing voices commanding him to kill people.

Patients transferred to HBT and CMHT will be considered in daily zoning meetings so that escalating risk can be identified at the earliest opportunity and appropriate actions taken. Zoning is a whole team approach to care enabling a targeted clinical response that can adapt quickly to changes in service users needs and risk. It encompasses a traffic light system whereby service users are placed in different zones dependant on level of need and risk, which determines the type of interventions that are offered.

Patients at risk of disengagement will be considered in zoning meetings by the enhanced CMHT and if required can be managed by the Manchester Engagement Team working alongside the CMHT. The integration of this team and its functions in the divisional structures is part of the ongoing transformation work in Manchester.

There is also ongoing work to enhance the provision of substance misuse treatment to patients with closer working with the providers of substance misuse services in the city and further training and support for CMHT staff within GMMH.

In addition we are working with colleagues in the Trust's forensic services to develop in-reach forensic support in the management of high-risk/ MoJ patients in the community, especially in areas such as Central West CMHT with a higher proportion of such patients. This will facilitate improved risk assessment and management, forensic opinion and case conferences.

Valuable background information was not circulated to those involved in the attacker's treatment with the result that they were deprived of the crucially important medical history that would have signposted the potential risks (particularly if the attacker was no longer taking the medication which controlled his schizophrenia and had once again resorted to using illicit drugs). An example of this concerns a 20 page Discharge reported prepared in January 2013 by a Consultant Forensic Psychiatrist at the time the attacker was being prepared to leave Ashworth High Security Psychiatric Hospital. This was not seen at the material time by the Care Co-ordinator, the GP nor the Consultant Psychiatrist who undertook treatment on two different psychiatric wards and in the community.

Patients with a significant forensic history are now being identified on the newly developed special notes system within AMIGOS the current Electronic Patient Record used in our Manchester services so that individuals presenting will have care plans and discharge plans, which are informed by these risks.

GMMH has developed a business case to introduce the PARIS electronic clinical record system bring our Manchester services in line with the wider Trust. This has now been approved by the GMMH Trust Board and will be introduced over the next 12-15 months. This will further enhance accessibility of these assessments to the treating teams.

On three occasions during 2015 other clinicians who encountered the attacker recommended that a Mental Health Act assessment be considered with a view to the attacker being sectioned. These recommendations were not acted upon. Judgements were made by Consultant Psychiatrists that the attacker was not detainable. These judgements merited a second opinion at the last, preferably by a Forensic Psychiatrist. Had the issues been evaluated with the benefit of the forensic history, the attacker's propensity to violent conduct may well have triggered a Mental Health Act Assessment.

Following learning from Mr Lound's death GMMH are currently developing proposals for forensic in-reach to support Consultants, CMHTs and in-patient services in Manchester, particularly around second opinions of service users. We are specifically looking at job planning forensic sessions in areas of Manchester with increased numbers of high-risk patients to offer timely access to support advice and expertise in managing these complex cases.

The Trust transformational work streams have also identified the importance of the enhanced community model. One key element of this is to complete a caseload review in terms of both number and complexity of patients. We have also identified enhanced supervision of caseloads and review of complexity to ensure that workers are appropriately supported. As part of this work we have also identified the need to reduce consultant only caseloads significantly to ensure that the consultants are fully engaged with the multi-disciplinary teams for discussions on zoning, risk and prioritisation of high risk patients.

Gaps in record keeping hindered by the co-ordination of treatment. Examples included a void in the medical notes to explain why the murderer had been transferred from one acute psychiatric ward to another (with a different consultant and clinical team), a discharge in his absence taking place on 8 October 2015 without any record of a risk assessment having been produced or a plan as to how he was to be followed up and who was to be notified, nor an explanation as to who had authorised the "discharge in absence" and why this was done.

GMMH has developed a rolling programme for all healthcare professionals promoting the importance of good record keeping. This training is currently being delivered across our Manchester services and will incorporate the lessons learned raised following Mr Lound's death.

The importance of good record keeping will form an active part of the ongoing audit supervision of all clinical staff.

Yours sincerely

Beverley Humphrey
Chief Executive

[redacted]