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Our Ref: JR/PS
Your Ref: 63377 03/01/2019

20 September 2019

Ms J Kearsley
HM Senior Coroner
Greater Manchester North
HM Coroners Court
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

Dear Ms Kearsley

Re: Regulation 28 Report to Prevent Future Deaths following the Inquest into the Death of Gregory Rewkowski – final update

In the first part of 2019, your office made the senior representatives from GMHSCP, GMCA, GMP, NWAS and Pennine Care NHS Foundation Trust aware of a shared responsibility to take action and improve the joint service response in the event of immediate risk to life arising as a result of mental health crisis in the community.

At the time, the jury from the inquest into Mr. Rewkoswki's death reached the conclusion, on the balance of probabilities, that the failings of the system 'did not make any contribution' to his death. Nonetheless, the view of HM Coroner was that "the lack of knowledge of procedures and policies of all services led to a delay in acting in a timely and appropriate manner" and that "unless matters heard were not addressed, there was a risk of future avoidable deaths."

We collectively acknowledged and accepted this critique. In our response to the regulation 28 letter which you issued, we confirmed that all organisations accepted a need to review internal policies; to put into place interim guidance; and to improve in the longer-term their approach to similar cases going forward. We committed to a programme which would review our multi-agency protocols, shared resources, and formal joint working action plans.

Furthermore, we committed to involve partners unrelated to the specific case in question, Greater Manchester Mental Health (GMMH) NHS Foundation Trust; and North West Boroughs Healthcare (NWBH) NHS Foundation Trust. This action was taken with a view to ensuring that the work-stream dedicated to addressing the issues identified in your report would produce an improved service offer, consistent across the entire city region.

As set out in my original letter, we also committed to contact you six months from the outset of the work in order to inform you of steps taken to address your concerns. I am therefore contacting you to notify you of progress made.

We identified eight issues which required attention, and specified that relevant task and finish groups would be convened to address them. These eight themes were:

- A common understanding of the duties, powers and training of staff in the respective agencies in their response to demands for service from people with mental ill-health.

- Improved information sharing processes through the development of the multi-agency 'Mental Health Control Room Triage' pilot service, jointly funded by NHS commissioners and the Greater Manchester Combined Authority, and district multi-agency safeguarding hubs.

- An agreed risk assessment framework, which takes account of increasing demand from reports of social media content and is applied by all agencies. It should address inconsistencies in the categorisation of incidents reported as concern for welfare and/or life at risk.

- Agreed, common service levels for assessed risk. In the short term through existing blue light services but in the medium term through increasing the capacity of first responders with mental health specialism – towards parity of response with physical harm.

- Escalation procedures where agencies differ in their assessment of risk, or where they are otherwise unable to deliver the agreed service.

- Access to adequate community mental health 'Crisis and Home Treatment Team' capacity for follow-up and discharge support out-of-hours (rather than inpatient staff) – especially for existing service users at higher-risk of repeated suicide attempts.

- Effective communication with middle managers and front line staff to ensure consistent service delivery and in particular that relevant frontline staff are clear about their responsibility to share information at the point of crisis and feel confident in doing so.

- Enhanced inter-agency communications to ensure accurate reporting and evaluation of all assessments and actions undertaken by blue-light partner agencies – in response to calls about concerns for welfare or life at risk.

Several distinct sessions were convened to review, revise and enhance our existing procedures from multiple perspectives. These sessions each included insight and oversight from all partner organisations named in this letter.

We have now drawn together a pan-GM protocol for response, developed specifically in order to achieve a common understanding of roles and responsibilities; to ensure a shared view of risk; and to promote communication and escalation at the first point that a common understanding may falter.

Clearly, it is one thing to develop protocols, and quite another to embed them across the workforce. For this reason, we will now seek to embed these protocols within their respective agencies. I will ask them to agree to do so at a coming meeting of a new GM Responding to Crisis Board – a meeting I have convened in part in response to a common desire all partners have to enhance our broader offer around members of the community confronted with such risk. This Board will hold responsibility as part of its work programme for ensuring that these protocols are cascaded, rooted, and delivered upon.

We also welcome recent commitments set out in the NHS Long Term Plan on the matter of crisis care, and are making a concerted effort locally to imbue our local services with every opportunity afforded by new resources which central government have set out to provide.

We welcome your own engagement with our Suicide Prevention Executive, and value your contribution to this work. Given your increased involvement in our partnership, we would gladly offer an opportunity for you to meet with key strategic leads who have delivered this work in order to better understand it. This would grant you an occasion to discuss the deliverables of work undertaken, and the process by which we have arrived at them. It would also grant an opportunity for you to quality assure our thinking and work to better meet the needs of individuals such as Mr. Rewkowski.

I hope you will agree that this has been an important first step in addressing the issues you outlined in your original report.

Yours sincerely

Jon Rouse CBE
Chief Officer
Greater Manchester Health and Social Care Partnership