Pennine Care
NHS Foundation Trust

Service/Department Name
Trust Headquarters
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Ashton-under-Lyne
Lancashire
OL6 7SR

Telephone: 0161 716 3000

10th January 2019

Strictly Private and Confidential
Alison Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Matthew Craven – DOD 19th April 2018

I write following the Inquest of Matthew Craven heard on the 1st November 2018. Your concerns after hearing all the evidence had been brought to my attention and I have subsequently reviewed the Regulation 28 letter.

I am writing to respond to the concerns raised into the circumstances surrounding the tragic death of Matthew Craven. The matters of concern raised and the actions we will take to address these concerns are as follows:

1. **There is no challenge or escalation process within the Trust to deal with situations where referrals are rejected by the psychiatrist.**

We will develop a process and protocol for escalation to be used within the borough of Stockport by the end of February 2019.

2. **There are no agreed targeted timescales for the offering of routine appointments**

Following review with the Lead Consultant Psychiatrist the agreed target timescales for routine appointments is 12 weeks. Clear communication of the target timescales will form part of the action above.

3. **There had been a series of presentations at the emergency department and RAID referrals. The inquest heard that there was no documentation or rationale provided for why RAID did not refer him to a Psychiatrist.**

Whilst there were assessments in ED that didn't result in a referral to a psychiatrist the investigation completed by Pennine Care into the death of Matthew, identified there is evidence on 9th April 2017 that the plan following the RAID team

assessment was to discuss his presentation and medication with the Consultant Psychiatrist and a referral made. On 10th April 2017 the referral for an outpatient appointment was not accepted but the consultant considered the information presented and recommended an increase in medication. Stockport borough will produce an escalation protocol for staff to use when there is disagreement regarding the need for a face to face appointment with a psychiatrist. This will be completed by the end of February 2019.

4. **Matthew had one admission to the acute hospital following an overdose and had been seen by an alcohol worker from the Mental Health Trust. There was no evidence that there had been any checking of previous engagements with mental health services. Information about this admission had not been shared with wider mental health services within the same trust.**

Pennine Care's alcohol liaison practitioners are moving to be based at Stepping Hill Hospital with the all age liaison mental health service and will form part of the same team which will significantly reduce the likelihood of any such concern arising again. The new model will be in place by the end of February 2019.

I hope that the information provided offers assurances that the findings of your investigations and the areas highlighted for the prevention of future deaths have prompted action and are a focus of our continuing commitment to improving mental health services in Stockport.

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

Yours sincerely,

C L Baker.

Executive Director of Nursing, Healthcare Professionals and Quality Governance

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