Our services:
Emergency and urgent care
Non-emergency patient transport
NHS 111

NHS
North West
Ambulance Service
NHS Trust

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HM Assistant Coroner Cox
H M Coroner's Court
Phoenix Centre
Heywood
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11 June 2020

Dear HM Assistant Coroner Cox

INQUEST TOUCHING UPON THE DEATH OF JASON PENDLEBURY

I write further to Regulation 28 Report which you issued against the Trust on 12 March 2020, following the conclusion of the Inquest touching upon the death of Mr Jason Pendlebury.

I understand that a copy of this response will be shared with Mr Pendlebury's family and, on behalf of North West Ambulance Service, I wish to express my sincere condolences for their loss.

This Regulation 28 report was jointly issued to North West Ambulance Service and Greater Manchester Police. By this letter, I wish to address the matters that you raised specifically to NWAS and I address each of those in turn below:-

1. **It was not clear from the evidence that the NWAS mental health nurses carrying out telephone assessments were aware of the number of calls that had been made to GMP or of THE previous telephone assessments. The fact that telephone assessments had been carried out were not communicated to the Deceased's GP**

When an NWAS mental health nurse carries out a telephone assessment, they would only be aware of a previous assessment by GMP or previous calls to GMP if this is communicated to NWAS by the police and documented by the call taker. GMP, and indeed any police force or emergency service, would be expected to share any information they felt to be pertinent. Once a clinician has completed an assessment, or returned the incident to dispatch if unable to carry out a triage, NWAS would not be made aware of any further updates from GMP as the clinicians no longer have sight of the incident.

NWAS mental health nurses would, however, be aware of previous calls to NWAS. It is common practice to check previous calls so an NWAS mental health nurse would be aware if a patient had been assessed by another NWAS clinician previously and what the outcome was.

With regards to communication with Mr Pendlebury's GP, Mr Pendlebury was advised to contact his GP and on one call he stated he was due to visit his GP therefore information was not sent separately by the clinicians. The process within NWAS has now changed. The Adastra system now ensures that all patients who are referred or discharged with self-care

advice and, therefore, do not receive an ambulance response have an automatic Post Event Message sent to their GP, which would provide an overview of the 999 call.

2. **The general quality and systems of communication regarding concerns relating to potential mental health needs between GMP and NWAS and onward communication to General Practitioners and Approved Mental Health Practitioners tasked with assessing risk levels**

The Trust jointly chaired a task and finish group with GMP, which was set up last year in response to a Regulation 28 report issued by Ms Joanne Kearsley in December 2018 to Greater Manchester Health and Social Care Partnership, Greater Manchester Combined Authority, Greater Manchester Police, North West Ambulance Service and Pennine Care NHS Foundation Trust. It was agreed that enhancements to the response around concern for welfare, and particularly risk to life, must be applied on a pan-GM basis, therefore Greater Manchester Mental Health NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust are also partners, despite not being involved in the specific case in question.

The task and finish group was established 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 by looking at risk assessment, risk management and inter-agency communications and procedures.

The sad case of Mr Pendlebury took place before this task and finish group was commissioned, however four of the eight issues identified as requiring attention by the task and finish group are relevant to the care provided to Mr Pendlebury and ultimately, to the prevention of future deaths. Those issues are:

- 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
- 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 for welfare or life at risk

The task and finish group has drawn together a pan-GM protocol for responding to ‘risk to life’ where it presents as a result of mental health to blue light services 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.

The Greater Manchester Clinical Assessment Service (CAS) was piloted from March-June 2019 and re-commissioned from November 2019-July 2020. In April 2020, mental health providers joined the CAS and it went live with referrals for clinically triaged patients who call

999 or 111. The current process is that NWAS Clinical Hub will identify two mental health incidents per hour from 999 or 111 that are either a Category 3 or Category 4 mental health incident. The incidents for referral would be clinically reviewed, ideally by a mental health practitioner, for suitability of referral to the GM CAS. Secondary triage is then undertaken by a GP from the GM Alliance.

This referral process was only due to go live in 2021, but has been brought forward in light of the current COVID-19 pandemic. The pandemic has otherwise impacted the ability of the respective organisations to operationalise the pan-GM protocol, with regards to the time commitment required and the fact that the system is in a state of flux, with significant changes being seen across mental health services. All organisations remain in a response phase to COVID-19 and a period of stability will be required for each organisation to re-assess the protocol.

In the meantime, a meeting has been arranged with Ms Joanne Kearsley and key strategic leads of the task and finish group. This meeting has been cancelled on previous occasions but is currently diarised for July. The Trust should be grateful if you would allow us to provide an update following that meeting and within six months of the date of this letter to report the work that has been undertaken to better meet the needs of individuals such as Mr Pendlebury and those in mental health crisis in the community.

Yours sincerely

[redacted]

DAREN MOCHRIE QAM, MBA, Dip IMC RCSEd, MCPara
Chief Executive